

PERCEIVED DIFFERENCES BETWEEN INDIVIDUAL AND
CO-THERAPISTS IN STRATEGIC MARITAL THERAPY

BY

GLEND A ELAINE ISENHOUR

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

1986

This is dedicated to
Caroline René Flinchum,
my daughter and my best friend.

I love you.

ACKNOWLEDGMENTS

I have mixed emotions as I realize the completion of my doctoral studies is truly near. This academic journey is not unlike a dream, with parts very hazy and unreal while other parts of the dream are remembered vividly and in great detail. Foremost in my dream of accomplishment are the wonderful people in my life who have either directly or indirectly influenced my choices and motivated me toward my goals. A very special note of thanks is written here for those people.

I wish to thank the members of my committee, Drs. Peggy Fong, Larry Loesch, and Leonard Beeghley, for their suggestions, editing, and support throughout the writing and rewriting of my dissertation. It is impossible to thank adequately Dr. Peggy Fong for all the teaching, guiding, and weekend reading she has done to help me stay focused and on task during my doctoral studies. She is a deeply committed professional and a loving individual. I am fortunate to know her, to have trained with her, and to include her as a friend. I wish also to thank Dr. Paul Fitzgerald and Dr. Joe Wittmer for all the opportunities they gave me to expand my resume and for their kindness and generosity.

A warming and loving thank you goes to my grandmother, Nellie Isenhour Waddell, who has taught me through example how to love unconditionally and who has always welcomed me home, regardless of my faults. I offer a special thank you to my Mom and Dad who taught me how

to meet new people, survive on my own and instilled in me a sense of pride, responsibility and perserverence.

I thank my very dear friend, April McKnew, who always has time for me when I need her, never forgets my birthday and has given me the most honest and caring friendship I've ever known. I feel blessed by this friendship that permits me to be myself and still be loved. I am truly indebted to Bert Flinchum, who has given me inordinate amounts of encouragement and support these past few years and, although we've changed the nature of our relationship, I have great respect for him and treasure his friendship. Also, a special thanks to Martha Flinchum, whose kindness to me is truly a gift for which I am grateful. I extend a very loving thank you to Gary Seiler, who has listened to my depressed signs, attended to my frantic and often hysterical requests for help, and who has taught me to celebrate each completed step, rather than waiting for the end of the race. I deeply appreciate the special friendship of Camilla Jones. We have traveled many different paths over the past 15 years, but our bond has always been strong despite our differences. Her encouragement and wit have been great sources of strength for me. Candy Spires deserves a very special award as she has taken care of me at work this past year, corrected my mistakes, listened to my complaints and given me encouragement and assurance that the chaos would not last forever.

I am grateful to Betsy Gregg, Pat Dean, Ellie Virtue and Dan O'Toole for their belief in me and for their encouragement to pursue graduate work, to Nancy Bolt and Diane Evans for showing me professional

and personal balance in life, and to Sue Hines, Susan Wall, Annette Bruscino, Pete Peterson, Linda Galloway, Tom Harrison, Ted and Kedrin Purcell, and Rainie Camp for being my friends.

Judy Nickles and Sharen Thomas are two young women that I have been honored to know and who are extraordinary examples of courage and determination. Both women have been confronted with unfortunate circumstances in their lives, but they have not given up nor given in. I know many others share in my admiration for them both.

TABLE OF CONTENTS

ACKNOWLEDGMENTS.	iii
ABSTRACT	viii
CHAPTER	
ONE	INTRODUCTION. 1
	Statement of the Problem. 8
	Purpose of the Study. 10
	Rationale for the Study 10
	Definitions 12
	Organization of the Study 15
TWO	REVIEW OF THE LITERATURE. 16
	Marital Therapy 16
	Consumer Beliefs and Expectations About Counseling. 28
	Summary 39
THREE	METHODOLOGY 41
	Population. 41
	Sample and Sampling Procedures. 43
	Independent Variable. 45
	Dependent Variables 48
	Experimental Design 51
	Procedures. 51
	Hypotheses and Research Questions 52
	Data Analysis 54
FOUR	RESULTS 55
	Sample. 55
	Hypothesis Number One: Social Influence. 56
	Hypothesis Number Two: Facilitative Conditions 58
	Other Consumer Responses. 60
	Summary 66

FIVE	DISCUSSION.	69
	Discussion of the Results	69
	Limitations	73
	Implications.	74
	Recommendations for Future Research	75
	Summary	76
APPENDICES		
A	IMPROVING FAMILY COMMUNICATIONS AND ENRICHING RELATIONSHIPS BROCHURE.	79
B	VIDEOTAPE SCRIPT.	82
C	EVALUATIVE QUESTIONNAIRE.	95
D	INFORMED CONSENT FORM	97
E	DEMOGRAPHIC INFORMATION	99
	REFERENCES	100
	BIOGRAPHICAL SKETCH.	107

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

PERCEIVED DIFFERENCES BETWEEN INDIVIDUAL AND
CO-THERAPISTS IN STRATEGIC MARITAL THERAPY

By

Glenda Elaine Isenhour

August, 1986

Chairman: Margaret Fong
Major Department: Counselor Education

This study examined potential consumers' perceptions of marital therapy modalities. Thirty-four females and 19 males, ages 25 to 50, with yearly household incomes over \$27,000, who had no prior couples therapy, volunteered their participation to test the hypotheses that there are no differences in potential consumers' perception of social influence or facilitative conditions among an individual male, individual female, and co-therapy team in strategic marital therapy. Participants also rated level of helpfulness, perceived fee for service, and most and least important aspects of the counseling session. Twenty-six individuals, laboratory school parents, exchanged participation for a 2 1/2 hour family enrichment workshop, and 27 V.A. Hospital employees exchanged participation for a luncheon.

One of three videotapes, 20-minute re-enactments of a strategic marital therapy session, was randomly assigned to one of three selected

days at each site. One group viewed and evaluated a co-therapy team, group two an individual female, and group three an individual male therapist. The Counselor Rating Form (CRF) and the Revised Barrett-Lennard Relationship Inventory (BLRI), effectiveness measures based on social influence and core facilitative conditions, were selected.

Multivariate analysis of CRF responses failed to reject the social influence null hypothesis. No significant differences were found among the three modalities when conducting strategic marital therapy across attractiveness, expertness, and trustworthiness dimensions, $F(6,86)=1.6$, $p=.153$. Multivariate analysis of Revised BLRI responses failed to reject the facilitative conditions null hypothesis. No significant differences were found among the three modalities when conducting strategic marital therapy across acceptance, empathy, and genuineness dimensions, $F(6,90)=.53$, $p=.7845$.

Chi-square analyses revealed no significant differences among modalities and cost, $\chi^2(14)=12.386$, $p=.575$, or modalities and level of helpfulness, $\chi^2(14)=22.573$, $p=.068$.

A frequency count revealed opportunity for the couple to express themselves and their feelings as the session's most important aspect across all modalities. Participants identified excessive time on future "what ifs" as the least important aspect of the session.

These results suggest an additional therapist in conducting marital therapy may not be warranted. The researcher suggests marital therapy training focus on the individual modality approach.

CHAPTER ONE INTRODUCTION

Marriage has long been viewed as a partnership with built in complexities; today, however, stressors on marriage are greater than ever before. Changing attitudes toward divorce and multiple marriages, birth control and the implicit "sexual freedom," and the struggle toward equity in the roles of men and women have had both positive and negative impacts on contemporary married couples. These and other changes have created new questions and difficulties not confronted by past generations of married couples.

As a result, 50% of all marriages, more than a million couples a year, end in divorce (Meer, 1986; Press, Burger, Abramson, McCormick & Cavazos, 1983). The traditional family—husband, wife, and children—is becoming less and less common. Considering these facts, the need for marriage counseling of distressed couples becomes apparent. These statistics also suggest a need for premarriage therapy and marriage enrichment as preventive measures to help couples prepare for the stresses of marriage. Marital therapy is a method of intervention to help answer questions and bring about change to the distressed marital relationship.

The discipline of marital therapy is quite diverse. The last 10 years have seen a proliferation of theories and therapeutic techniques that either explain and/or deal with marital dysfunction. Currently

receiving the most attention in the professional literature are three major theoretical orientations which form the base for marital therapy approaches: insight theories such as psychoanalytic, transactional analysis and gestalt; learning theory, of which behavioral is the best known; and, general systems theory, including, but not limited to structural, strategic and multigenerational theories (Boszormenyi-Nagy & Spark, 1973; Bowen, 1966; Haley, 1973, 1976; Liebman, Minuchin, Baker & Rosman, 1976; Minuchin, 1974).

Within each of these theoretical orientations are yet more variety and diversity of opinions, methods, and techniques. Most therapists employ one or more theoretical approaches and a variety of techniques as well as one or more modalities (Sager, 1981). Framo (1981), a systems theorist, characterizes this flexibility in his personal statement: "My therapeutic philosophy is to learn as many kinds of approaches as possible in order to have a full repertoire of techniques available to shift a system" (p. 146).

The use of co-therapists versus an individual therapist in the fundamental structuring of the therapeutic session is one element of divided opinion. Both individual and co-therapy approaches have been advocated as beneficial to the therapy process. Quite often the marital therapy literature merely references "the therapy team" or "the therapist" without addressing the condition at all. Co-therapy has been identified as helpful in a number of ways. Russell and Russell (1979) identify co-therapy as a therapeutic or symbolic marriage in which two people come together for the treatment of a group or family.

Heterosexual co-therapy has been claimed useful as a method of developing gender identity and construction of a family image (Soone & Lincoln, 1965, 1966). Others view co-therapy as a natural constellation of parenting (Napier & Whitaker, 1978; Skynner, 1976; Treppa & Nunelly, 1974), allowing one therapist to be maternal, protective and risking over-involvement while the other can be paternal, incisive or neutral. MacLennan (1965) offers yet another point of view, identifying three different purposes for co-therapy: the enhancement of the treatment process, support of the other therapist, and/or training of a less experienced therapist by a more experienced therapist.

Very little empirical research is available on the actual utility of co-therapy (Roman & Meltzer, 1977). Haley (1976) passionately asserts his uncompromising belief in the wastefulness and irrelevance of the practice of co-therapy. He chooses instead to utilize other therapists as supervisors and as a treatment team through the use of a one-way mirror. Whitaker and Keith (1981), however, argue with equal strength that co-therapy is almost always a necessity.

Whitaker and Keith (1981) contend that the use of co-therapy

1. allows more creativity and variability in functioning, which in turn gives more power to the co-therapy team;
2. decreases the likelihood of disregarding subjective perceptions;
3. decreases the intrusion of the therapist's pathology;
4. allows the therapist the freedom to think; and
5. prevents stealing one of the clients to become a therapeutic helper.

In addition, the support of a co-therapist allows the therapist to be more open, honest and personal which can push clients into adopting or modeling similar characteristics (Nadelson & Paolino, 1978; Whitaker & Keith, 1981).

As with the use of co-therapy, the helpfulness of an individual therapist is rarely referred to but rather assumed in the marital therapy literature. During the early development of structural therapy, therapists worked primarily with low-income couples and families. Co-therapy, at that time, was more the rule than the exception (Aponte & VanDeusen, 1981). In more recent years, with more practitioners working with middle-class couples and families, the trend has moved toward an individual therapist in the therapeutic session. It is supposed that the transactional processes utilized by the structural therapist are more easily controlled by a single therapist. It is the technical difficulties of the continuous and coordinated therapeutic efforts that have encouraged the individual modality among structuralists (Aponte & VanDeusen, 1981).

Other theorists believe that they must first join the family before trying to bring about change, an accomplishment less complicated and speedier if attempted alone (Minuchin, 1969; Russell & Russell, 1979). Still others support positioning oneself as the observer and resource or data collector, a style also supported as best accomplished alone (Ackerman, 1966; Bowen, 1966; Satir, 1967).

Very often advocates of the individual therapist modality cite what they believe are the many disadvantages of co-therapy, rather than the

advantages of the individual therapist modality, to support their own personal style. They contend that the necessity for therapists to have known each other long enough and worked together extensively enough to have developed a mutually facilitative team rather than merely the ability to stay out of each other's way is a grave disadvantage to the co-therapy approach. Nadelson and Paolino (1978) suggest that there is also potential for conflict when the co-therapists have not worked out their own competitive or status-oriented conflicts. Framo (1981) and Nadelson and Paolino (1978) suggest that co-therapy difficulties may add confusion for some couples in therapy, reviving negative parental transference images that interfere with the therapeutic process, or the couple may "take on" the therapists and try to "cure" them.

While the co-therapy approach generally includes a male and a female therapist, the gender of the individual therapist could potentially influence the consumer. The influence of the therapist's gender on the consumer continues to be an issue of discussion and controversy in the psychological literature. There have been several studies including college and non-college men and women stating a preference for a therapist of the same sex (Persons, Persons, & Newmark, 1974; Simons & Helms, 1976). These researchers report that the consumers viewed the same sex therapist as more helpful, better able to understand their problems, and more genuinely interested in them. However, in a study of 99 former therapy clients, Jones and Zoppel (1982) report that regardless of gender, clients agreed that female therapists formed more effective therapeutic alliances than the male

therapists but that both male and female clients of male therapists reported significant improvement as a result of therapy. To further confuse the issue, in a study of 240 college students on the expected behaviors of therapists, Sublich (1983) found no differences in the expected behaviors based on the therapist's sex.

While these results are contradictory, research studies generally agree about the complexity of examining and interpreting gender influence. Similarly, many of the results point to the therapist's gender as a multidimensional factor and argue that research to date on gender reports no important differences on outcomes associated with the sex of the therapist or client (Jones & Zoppel, 1982; Kunin & Rodin, 1982; Sublich, 1983). Because it is unknown exactly how gender influences the consumer's perceptions, it is a necessary consideration in studies of marital therapy.

At present there is an absence of research in the area of marital therapy that supports the use of one therapeutic approach over another (Gurman, 1978). Researchers in marital therapy have been slow to develop the methodological sophistication necessary to answer such questions. Williams and Miller (1981) have identified four probable causes: much of the research in this field is conducted by beginning investigators who lack extensive research experience; it is difficult to assess and quantify the outcome of marital therapy; marital therapy research is costly due to the large numbers of couples and numbers of different therapists needed; and there is a lack of interest and involvement in the field of marital therapy on the part of academic

clinical psychology departments. Considering these research difficulties and the lack of studies to determine the efficacy of co-therapy over the individual therapist approach, it is useful to focus on the desires and preferences of the consumer in making decisions on approaches, techniques, and/or modalities.

One way to examine the relative helpfulness of individual therapist versus co-therapists is from the point of view of the consumer. Both theoreticians and practicing therapists have long been in agreement that clients bring expectations and beliefs to the counseling situation (Dell & Schmidt, 1976; LaCrosse, 1977; LaCrosse & Barak, 1976). The therapist characteristics shown repeatedly to influence the therapeutic session are acceptance, attractiveness, empathy, expertness, genuineness, and trust (Barak & Dell, 1977; Barak, Patkin & Dell, 1982; Tinsley & Harris, 1976). Taking a social influence view, Strong (1968) reports that it is the characteristics of the communicator as perceived by the audience, characteristics of the audience, and characteristics of the communication that affect the success of the therapy attempted. It is with this research information that salespeople, writers of television and radio commercials, clinicians and educators have learned to value the importance of the consumer's perceptions from selecting a box of detergent to selecting a therapist. The perceptions of the potential consumer have not yet been investigated regarding the use of an individual therapist versus co-therapists in marital therapy.

Statement of the Problem

Gurman and Kniskern (1981) state that to date there are no persuasive data supporting the superiority of an individual therapist over co-therapists in marital therapy. Both Jacobson (1978) and Whitaker (1972/73), influential figures in the field of marital therapy, have expressed the need to evaluate the utility of co-therapy over individual therapy. Both time and expense of an additional therapist in co-therapy are issues needing consideration (Russell & Russell, 1979). Only if couples benefit more from co-therapy than individual therapy can an additional therapist be recommended.

There is only one known controlled outcome study to date addressing the issue of co-therapy versus individual therapy (Mehlman, Baucom & Anderson, 1983). In addition to evaluating the overall effectiveness of behavioral marital therapy in helping distressed couples, Mehlman et al. explored the relative effectiveness of co-therapists versus a single therapist and immediate treatment versus delayed treatment. Thirty maritally distressed couples, selected from an outpatient psychology clinic of a university psychology department, were randomly assigned to one of six treatment conditions, five couples per condition:

1. immediate treatment by a male therapist;
2. immediate treatment by a female therapist;
3. immediate treatment by both the male and female therapists;
4. delayed treatment by a male therapist;
5. delayed treatment by a female therapist; or

6. delayed treatment by the male and female therapists.

Regardless of the type of therapist, each couple's therapy consisted of five weeks of training in problem solving and communication skills followed by five weeks of training in quid pro quo contracting. Procedures for both the co-therapy team and the individual therapists were reported as identical. They reported that co-therapists were not significantly more effective in producing improvement in distressed couples than the individual therapist. The researchers stress their findings should be generalized no further than the skills-oriented treatment of behavioral marital therapy in selecting a marital therapy modality. They state further that the usefulness of co-therapy in marriage therapy may vary according to the functions being served by the therapist within the particular treatment strategy and that further research in the area of modality is necessary.

In summary, the literature identifies a variety of theories and techniques in the area of marital therapy. Also identified in the literature is the difference in the modality employed when conducting marital therapy. Presently there is a lack of empirical data to support the effectiveness of an individual therapist or co-therapists as a therapeutic preference. Additionally, there is no information available addressing the differences between an individual therapist and co-therapists as perceived by a consumer population.

Purpose of the Study

The primary purpose of this study was to compare potential consumers' perceptions of the effectiveness of co-therapy and individual therapy in marital therapy as a step toward determining the relative value of individual therapist versus co-therapists in marital therapy. This study compared a potential consumer population's perceptions of the effectiveness of co-therapists and an individual therapist in terms of their perceived acceptance, attractiveness, empathy, expertise, genuineness, and trustworthiness. As a secondary purpose, this study examined several issues thought to be relevant to consumers. The potential consumers were asked to estimate cost, provide an overall rating of helpfulness and identify the most and least important aspects of the counseling session from their perspective.

Rationale for the Study

The marital therapy literature cites numerous advantages and disadvantages of the use of both co-therapists and an individual therapist. There are five important issues related to marital therapy potentially influenced by this study.

Cost

The issue of cost is an important consideration for this study. The cost of the "therapeutic hour" is an important concern for most

individuals and couples interested in participating in therapy. Certainly the expense of using two therapists for one session is passed on to the consumer. In this study the potential consumer, whose perceptions of the therapists greatly influence the therapeutic outcome, determined whether there were significant differences between the two modalities, indirectly addressing the additional expense of co-therapy.

Time

A second factor, and closely tied to the expense of therapy, is the use of time. In co-therapy two therapists spend the hour with one couple. This study added data discouraging co-therapy as an efficient use of therapeutic time by providing potential consumer information on perceived effectiveness of the modality.

Goal

A third rationale for this study focused on the innate goal of marital therapy which is to help, not hurt or confuse clients further. This study contributed information on the perceptions of the core components of therapy by potential consumers, indicating a choice for what appears to be the most helpful mode for marital therapy.

Training

The data from this study have implications for the training and development of marital therapists. Data from this study indicates a need to focus on more specific training of individual marital therapists

rather than emphasizing the utility and value of the co-therapy team over the individual therapist.

Research

Finally, research in this area is extremely limited. This study contributed to the literature information concerning the potential consumers' opinions and evaluations of co-therapists and an individual therapist marital therapy. It was hoped that this study would spark reaction and interest for further research on the effectiveness and efficiency of the co-therapy team or the individual therapist approach to marital therapy.

Definitions

Acceptance—The clients' belief that the therapist is not evaluating or judging of them. The clients perceive the therapists as approving of them as individuals and of personal worth (Gazda, Asbury, Balzer, Childers, & Walter, 1977). In this study acceptance was measured by the scores on the Revised Barrett-Leonard Relationship Inventory (BLRI; Barrett-Leonard, 1962).

Attractiveness—The clients' belief that they and the therapist are similar in some way, either in background, opinions, or beliefs (Strong, 1968). In this study attractiveness was measured by the scores on the Counselor Rating Form (CRF; Barak & LaCrosse, 1975).

Co-therapy—The use of two therapists in psychotherapy. In this study co-therapy was defined as a team consisting of one male and one female therapist.

Conjoint therapy—One form of marital therapy where partners are seen together in the same session by the same therapist (Nadelson & Paolino, 1978).

Empathy—The clients' belief that the therapist is listening to them with full attention and that the therapist is understanding what the clients wish to be understood about themselves (Gazda et al., 1977). In this study empathy was measured by the scores on the Revised BLRI.

Expertness—The clients' belief that the therapist has some information, skill or ability to help them. This may be through objective evidence such as diplomas, certificates and/or titles; and/or the therapist appears rational and knowledgeable in argument and shows confidence through presentation (Strong, 1968). In this study expertness was measured by the scores on the CRF.

Facilitative Conditions—The degree to which the helper offers high levels of facilitative dimensions (empathy, respect, and genuineness) is directly related to the degree to which the client can understand, respect and be specific with themselves and others (Carkhuff, 1971).

Genuineness—The clients' belief that the therapist is real and honest, perceiving the therapist's behaviors and verbalizations to be congruent with the therapist's inner feelings (Gazda et al., 1977). In this study genuineness was measured by the scores on the Revised BLRI.

Individual Therapy—Psychotherapy conducted by a single male or female therapist.

Potential Consumer—A population of individuals who may be interested in a particular product or service, either now or in the future, but who have not yet purchased or experienced the commodity.

Social Influence Theory—The interpersonal dynamics which occur between helpers and helpees during face-to-face meetings. The dynamics center around the extent to which helpees see helpers as being an "expert," being interpersonally "attractive," and "trustworthy" (Strong, 1968).

Strategic Marital Therapy—A form of marital therapy where the clinician initiates what happens during treatment and designs a particular approach for each problem (Haley, 1973). In this study, strategic marital therapy was demonstrated on the videotape stimuli.

Trustworthiness—The clients' perceptions that the therapist is sincere and open and the therapist's behaviors are not motivated by personal gain (Strong, 1968). In this study, trustworthiness was measured by the scores on the CRF.

Organization of the Study

The remainder of this study is organized into four chapters. The second chapter is a review of the related literature. Topics discussed are a review of marital therapy and consumer beliefs and expectations about counseling including the social influence process and the facilitative conditions of therapy. The third chapter describes the research methodology, the population, sample and sampling procedures, the independent variable, dependent variables, experimental design, procedures, hypotheses and data analyses. Chapter four reports the results of the analysis of the hypotheses and the evaluation questionnaire. Chapter five presents a discussion of the results, limitations and implications of the study and recommendations for future research.

CHAPTER TWO REVIEW OF THE LITERATURE

The review of the literature in this chapter includes an overview of the diversity in theory and approach in marital therapy with a focus on strategic marital therapy. Also reviewed in this chapter is the literature related to consumer perceptions of counseling and counselors, including the social influence process and the facilitative conditions of therapy. Two instruments that measure perceptions of the therapist, the Counselor Rating Form and the Barrett-Lennard Relationship Inventory (instruments selected for this study), are also reviewed in this chapter.

Marital Therapy

During the last decade, marital therapy has become a significant mode of therapeutic intervention in the mental health field. Marital therapy has primarily been respected for its use in helping couples with overt marital conflicts. In addition, it is increasingly being recognized as a powerful intervention for a variety of clinical problems, such as affective disorders, substance abuse, alcoholism, sexual dysfunction and even obsessive and compulsive rituals, traditionally treated by individual psychotherapy (Gurman, 1979).

The clinical practice of marital therapy was established long before development of a marital theory. Much of marital theory has been adopted from established family theory. Three major factors have been credited with retarding the development of both the conceptual and the empirical base for couples therapy. Initially, contemporary marital therapy emerged as a response to the needs of clients (Olson, 1970) rather than through the advancement of a new theory or from basic experimental research which would have provided a theory base for investigation and operation. Secondly, the professional disciplines committed to marital and family study (psychiatry, clinical psychology, social work, family sociology, and the ministry) were unconnected and operated independently of each other. Because each discipline operated with differing value structures with vastly diverse clinical populations, developments were fragmented. Finally, interprofessional collaboration was retarded due to general devaluing of providing psychotherapy to marital systems coupled with the devaluing of treatment by non-physicians (Olson, 1970). In spite of these problems, the practitioners of marital therapy have developed methods of clinical investigation and intervention which, although overlapping occasionally with family theories, contribute to the understanding of the marital process and marital dysfunction.

At present there are three major types of theoretical orientation in marital therapy: insight-oriented, social learning, and general systems. In addition to their differences in therapeutic intervention, the role of the past in therapy, basic methods of assessment, the

therapeutic relationship, and the treatment modality also differ across these three orientations. Furthermore, within each of these orientations are a variety of more specific theories, each with its own specialized theory, method, and style.

A brief comparison of Psychoanalytic (an insight-oriented theory), Behavioral (a social learning theory), and Strategic (a general systems theory) theories will demonstrate some of the areas of diversity among these three orientations in marital therapy.

Role of the Past

To psychoanalytic therapists the roles of the past and unconscious are important, as they manifest themselves in present behaviors and thoughts. During treatment, the psychoanalytic therapist encourages the couple to explore the impact of the past on their relationship (Gurman, 1979). For behaviorists and strategic therapists, the role of the past is irrelevant to the treatment process (Haley, 1976; Jacobson, 1978; Jacobson & Weiss, 1978). They agree that current problems experienced by the clients are maintained by current forces within the relationship.

Psychoanalytic therapists view the presented problems as reflecting more basic, undisguised, underlying conflicts while the behaviorists and the strategists accept the presented problems primarily at face value (Nadelson & Paolino, 1978; Olson, 1970).

Assessment

Each model emphasizes careful, early assessment of the couple seeking treatment. Psychoanalytic therapists commonly conduct evaluations on the multiple aspects of the marital relationship. The behavioral therapists place great value and invest much energy in the utility of standardized evaluation instruments and their interpretation. The strategic therapists, however, focus on the initial presenting problem and do not routinely administer tests for evaluation or interpretation (Olson, 1970).

Therapeutic relationship

The view of the relationship established between the therapist and the couple is yet another area of difference among these approaches. The psychoanalytically oriented therapists believe that is the unique relationship that evolves between the couple and their therapist that is the vehicle of change. Effective treatment requires the application of expert technical knowledge and skills rooted in a deeply personal and emotionally intense relationship between the therapist and the couple (Nadelson & Paolino, 1978). The behavior therapists regard the therapeutic relationship as simply the interpersonal backdrop to facilitate application of highly specific technical interventions (Jacobson, 1978). Strategic therapists view the therapist-couple relationship primarily as a power struggle that, for the couple's good, the therapist should win (Haley, 1976). Both behavior and strategic

therapists regard the intervention process as more important than the therapist who conducts the process.

Modality—Co-therapists or Individual Therapist

A final difference for discussion is the composition of the therapeutic session. The traditional psychoanalytic approach to treatment is for each spouse to be seen individually, each having his or her own therapist. This method requires that the individuals assume responsibility for personal growth and change; allows for independent work, especially if one spouse has decided on divorce (Cookerly, 1973); and protects the confidentiality of each partner regarding such concerns as extramarital affairs, homosexuality, or past history. This modality has been criticized as having no effect on the marital disturbances within the partner (Sager, Gundlach, Kremer, Lenz & Royce, 1968), and is identified as a cause for marital dissolution. In utilizing this approach, the therapist is kept unaware of the nature of the marital interactions or of distortions, denial, omissions, or projections of the relationship that may occur (Nadelson & Paolino, 1978). There are some psychoanalytic recommendations for conjoint therapy, as when the partners are viewed as "poorly motivated" and "not ready" for individual treatment, when the problems involve acting out and are of a characterological nature, when there are gross distortions and disruptions in reality, and when speed is a critical factor in halting family disintegration (Watson, 1963).

Co-therapy, too, is recommended in psychotherapy, especially in the treatment of patients with sexual problems (Mintz, 1963). Among the reasons for recommending a co-therapist are the added flexibility in scheduling sessions and the development of a dyadic relationship with one therapist, which allows continuity of care if necessary. A co-therapist can support a partner who feels attacked or can react with a more appealing or tactful approach if the other therapist has produced excessive anxiety. The co-therapists can also act as a model for identification and support to the same-sexed partner or can help diffuse an intensely sexualized transference. From the therapist's perspective, mutual support, reinforcement and constructive criticism may facilitate therapeutic work (Nadelson & Paolino, 1978).

Psychoanalytic therapists note a disadvantage involved in the co-therapy approach is the potential for conflict between therapists who have not worked out their own competitive or status-oriented conflicts. Co-therapists may also be more confusing to some couples, reviving negative images and interfering with therapeutic progress (Nadelson & Paolino, 1978; Skinner, 1981). The expense and time components of co-therapy are cited as important considerations in a psychoanalytic therapist's recommendation for co-therapy (MacLennan, 1965; Nadelson & Paolino, 1978).

MacLennan (1965), a very adamant psychoanalytic researcher, strongly recommends against co-therapy. MacLennan contends that "flexibility in scheduling" negates the concept of co-therapy. She asserts that it is vulnerability and lack of refined skills that cause a

therapist to seek a therapy partner. She further states that co-therapy is more difficult to conduct than individual therapy and should only be used for special treatment purposes or for research by experienced therapists. If co-therapy is used for training, one of the therapists should be experienced for the protection of the clients. The potential countertransference between therapists, if allowed to get out of hand, may add to the clients' resistance and prove antitherapeutic. She believes co-therapy is expensive, complicated, and requires careful coordination. As long as there is a shortage of professional staff and a shortage of money to pay for them, MacLennan (1965) contends it is necessary to justify the use of more than one therapist in a session.

Most behavioral therapy is conducted by co-therapists, although there is no empirical evidence for its necessity (O'Leary & Turkewitz, 1978). It is often the modality of choice allowing the therapists to model interactions of the couple. At times the co-therapists discuss the couple's conflict between themselves, each presenting the argument of the same-sexed spouse. The sex therapy work of Masters and Johnson (1970) is deeply committed to a heterosexual co-therapy modality. They advocate the co-therapy approach which provides each partner with an "ally," someone who is able to understand his or her particular situation and feelings from a shared perspective. Kaplan's (1974) sex therapy work, however, takes a different approach. At the Kaplan training seminars, special efforts are made to raise the consciousness of their therapists to the psychosexual reactions of both genders. Those behavior therapists following Kaplan's design work alone.

Most strategic therapists do not engage in co-therapy as it is generally practiced, although they routinely work with one or more colleagues, who observe sessions from adjoining rooms and function as peer supervisors and/or consultants. Those observing may help out at times and even enter the room and take sides on an issue as a way of facilitating a change in the process (Weakland, Fisch, Watzlawick & Bodin, 1974). It is speculated that one of the reasons strategic therapists rarely do co-therapy is that very systematic and consistent control of the treatment process must be maintained during treatment sessions in this approach, and the presence of a second therapist would run the "risk" of introducing uncertainty and a less "united front" into the treatment (Stanton, 1981). Haley (1976) believes co-therapy is too problematic and prefers live supervision which uses the input of more experienced, but less visible therapists, in treatment. In the Brief Therapy Center of the Mental Research Institute, three observers participate in the marital therapy sessions behind a one-way mirror. They often telephone into the session with questions and/or advice for the therapist. This form of treatment permits someone other than the individual therapist to make interventions, precluding the possibility of the clients arguing with the therapist who delivers the question or advice and sparing the therapist the stigma of making a particularly painful or provocative remark to the clients (Bodin, 1981).

By contrasting these three theories, the differences and commonalities within the major therapeutic orientations become more apparent. One area discussed, therapeutic modality, revealed diversity

both among the three theories and within each theory. Both the individual approach and the co-therapy approach have advantages and disadvantages and each is advocated and rebuked by researchers in the area of marital therapy.

One such advantage of co-therapy is that it offers a useful role-model/role-playing device demonstrating active/passive, directive/non-directive, and giving/taking and providing an opportunity to modify male/ female role expectations and role flexibility (Duhl & Duhl, 1981; Hannum, 1980; Napier & Whitaker, 1978). Co-therapy dilutes the emotional drain of working with very pathological couples (Aponte & VanDeusen, 1981; Hoffman, 1976; Russell & Russell, 1979) and facilitates the therapeutic process by providing feedback to one another (Nadelson & Paolino, 1978; Napier & Whitaker, 1978; Skynner, 1981). Co-therapy is also widely used as a method of training in counselor education programs (Crowe, Gillan & Golombok, 1981; Dies, 1980; Roman & Meltzer, 1977; Siddal & Bosman, 1976; Russell & Russell, 1979).

Co-therapy teams with long-standing experience have been the most successful. These are therapist combinations that have negotiated their relationships through many difficulties and have learned how to communicate and negotiate efficiently and honestly both in and out of sessions. They understand one another's clinical thinking and range of skills, engaging in therapy that is spontaneously coordinated and flexible. Most importantly, they are sensitive and responsive to each other as people (Aponte & VanDeusen, 1981; Hannum, 1980; Rice & Rice, 1977).

In examining the individual therapist approach there is little in the therapy-related literature that directly addresses either its merits or its pitfalls. Instead, the virtues of the individual approach to therapy are more often alluded to indirectly through the researcher's negative critique of co-therapy.

Bodin (1981), who prefers the individual therapist approach, refers to one disadvantage of co-therapy as the need to have known one's co-therapist for a fairly long time or to have worked together extensively enough to have developed mutually facilitative teamwork rather than merely "keeping out of each other's hair." The potential for competitive or status-oriented conflicts is great in co-therapy (Haley, 1976; MacLennan, 1965; Nadelson & Paolino, 1978; Skynner, 1981).

Further, when employed as a training method, co-therapy has several potential hazards and is not always viewed as the most satisfactory for training approaches. MacLennan (1965) addresses the educational process of co-therapy as a unique opportunity to explore one's own countertransference. Her preference, however, is to create other opportunities and methods that would allow trainees to work on their own "basic neurotic conflicts" elsewhere. Arbitrary pairing of students, differing levels of experience, and different status team members are cited as additional co-therapy training problems (Hannum, 1980; Lothstein, 1980; Rice & Rice, 1977; Sonne & Lincoln, 1966).

In a review of research studies, Gurman (1973) compared improvement rates of all approaches to marital therapy. His findings did not support that those couples in treatment with a co-therapy team had

greater improvement than those in treatment with a single therapist. These findings contribute to the expense and time problems associated with introducing a co-therapist into the therapeutic setting (Gurman, 1979; MacLennan, 1965; Nadelson & Paolino, 1978).

The only known research in the area of individual therapist versus a co-therapy team was conducted by Mehlman, Baucom and Anderson (1983). They explored the relative effectiveness of co-therapists versus a single therapist. In their training of problem-solving and communication skills, followed by five weeks of training in quid pro quo contracting of 30 maritally distressed couples, they found no significant differences in improvement in those couples in treatment with an individual therapist and those in treatment with a co-therapy team. Mehlman et al. suggest these findings may be unique to the skills-oriented techniques of Behavioral Marital Therapy. Stating further that once a therapist has established proficiency in the teaching of these skills, an additional therapist will do little to add to the treatment process. They also suggest that another therapeutic approach may employ strategies that would make a co-therapist more necessary.

Perhaps the most often repeated statement in the literature concerned with modalities of therapy suggests the need for contrasting the single therapist and the co-therapy team counseling modalities with families and couples and in the various forms of therapeutic treatment (Gurman, 1971, 1973; Jacobson, 1978; Mehlman et al., 1983; Rabin, 1967; Rice & Rice, 1977; Russell & Russell, 1979; Williams & Miller, 1981).

Strategic Marital Therapy

Strategic marital therapy was selected as the therapeutic treatment for this study because of its highly active and interactional intervention characteristics in the treatment of distressed couples seeking therapeutic relief. Strategic therapy has been defined as therapy in which the clinician initiates what happens during treatment and designs a particular approach for each problem (Haley, 1973). The therapist takes responsibility for directly influencing people and the existing interpersonal system to bring about beneficial change. The strategic therapist wants the cooperation of the couple in the treatment process, but a joint collaborative effort is neither a requirement nor a necessity.

In strategic therapy, individual problems, or "symptoms" are considered manifestations of disturbances in the marriage. These symptoms are regarded as a result of misguided attempts to change an existing difficulty (Watzlawich, Weakland & Fisch, 1974). Symptoms are a communicative act, containing message qualities, that function as a type of contract between the two partners, serving a particular function within the interpersonal relationship. A symptom usually appears when a person, in an impossible situation, tries to break out. The marital relationship is defined as cyclic, with complex interlocking feedback mechanisms and patterns of behavior that repeat themselves in sequence. The strategic therapist assumes that elimination or reduction of the symptom results from a change in the system (Haley, 1973).

In strategic therapy, therapeutic change is brought about through the interactional process that occurs when the therapist intervenes actively and directly in particular ways (Haley, 1971). The therapist works to change the dysfunctional sequence of behaviors already existing in the marital couple through reframing and/or paradoxical interventions utilizing tasks and directives which are considered the main therapeutic tools (Stanton, 1981). Early discussion in a session is aimed toward acquiring the necessary information that will enable the therapist to prescribe a directive or task for the couple in treatment (Haley, 1976). Haley (1976) claims strategic therapy is designed to get results and to get them quickly. More than any other marital treatment during the past five years, strategic marital therapy has demonstrated its value by making the most advancements in the development of an innovative treatment model (Stanton, 1981).

Consumer Beliefs and Expectations About Counseling

At present, there is no empirical evidence that indicates the superiority of one therapy over another (Gurman, 1977; Jacobson, 1978; Marmor, 1966). There is, however, evidence available that indicates the client's perception of the therapist and the client's experience of the therapist play an important part in the therapeutic process toward change.

Social Influence Process

Strong's (1968) presentation of therapy as an interpersonal process is based on the cognitive dissonance theory of Festinger (1957) and an extension and elaboration of Goldstein's (1966) research in the area of social psychology. From his work, Strong hypothesized that a therapist's attempt to change a client's behavior or opinion would create dissonance by (1) changing in the direction advocated by the therapist, (2) discrediting the therapist, (3) discrediting the issues, (4) changing the therapist's opinion, or (5) seeking others who agree with the client. Extrapolating from research in social psychology, Strong (1968) postulated that the extent to which counselors are perceived as expert, attractive and trustworthy would reduce the likelihood of their being discredited. By increasing the client's involvement in counseling, the likelihood of discrediting the issue would be reduced.

In a review of social psychological research, Corrigan, Dell, Lewis, and Schmidt (1980) report that perceived expertness, attractiveness, and trustworthiness of a source are consistently implicated as important determinants of that source's ability to effect social influence. They note that by further expanding the social influence process; extrapolating from social psychological research; and utilizing the dimensions of expertness, attractiveness, and trustworthiness as useful in describing therapeutic performance, it may further be stated that the therapist's ability to influence their client may be affected by the

client's perception of the therapist as expert, attractive and trustworthy (Corrigan et al., 1980).

Tinsley and Harris (1976) examined the relative strength of a college student's expectations of counseling and investigated the relationship of these expectations to other client characteristics. A total of 187 undergraduate students (22 years old, with no prior therapy experience) were given a questionnaire regarding college students' expectations for counseling. The 82-item questionnaire rating was a Likert-type scale ranging from (1) slightly true to (7) definitely true. Questions covered counseling procedure; counseling outcome; the student's expectations of the counselor's genuineness, expertise, acceptance, understanding, directiveness and trustworthiness; and acceptance of responsibility for one's own improvement in counseling. The results of this investigation reported that the subjects rated strong expectations for the ability to trust the counselor and their perceptions of the counselor's attitudes and behaviors of genuineness, acceptance and the counselor's overall expertise.

In another study, Tinsley, Workman and Kass (1980) investigated several aspects of client's expectations about counseling. Four hundred and forty-six students from introductory psychology courses, all 22 years old or younger with no prior counseling experience, completed a 203-item Expectations About Counseling Questionnaire. This questionnaire is rated on a Likert format ranging from (a) not true to (g) definitely true and directed toward measuring the client's expectations regarding their own attitudes and behaviors, counselor attitudes and

behaviors, counselor characteristics, characteristics of the counseling process, and equality of the counseling outcome.

Sixty-eight items were dropped from the initial pool of 203 items, and 15 of the 135 items retained were assigned to scales different from the scale to which they were originally assigned. The internal consistency reliabilities of the 17 scales were judged to be sufficiently high to warrant their use in further research. The scales loading the highest were expectations that the counselor would be genuine, trustworthy, accepting and tolerant; that the counselor would sometimes confront the client; and that the counseling experience would be characterized by concreteness. There were also client expectations that the counselor would be directive, empathic, expert, accepting, self-disclosing, nurturant and attractive.

Counselor Rating Form

A number of studies have examined counseling as a process of interpersonal influence. Barak and LaCrosse (1975) investigated the existence of expertness, attractiveness, and trustworthiness dimensions in an analogue study. Using films of Perls, Rogers, and Ellis, the researchers had 202 undergraduates rate the therapists on 36 bi-polar adjective dimensions. The 36 items have been classified by judges into representing the perceived counselor dimensions of expertness, attractiveness and trustworthiness. The results indicate that all three therapists were described as being expert and attractive. Rogers and Perls were seen as trustworthy; however, this factor was not found to be

present in Ellis. The Counselor Rating Form (CRF) was developed to measure the perceptions of clients about their counselor in the areas of attractiveness, expertness and trustworthiness.

The validity and reliability of the 36-item Likert-type adjective inventory were established in another study (LaCrosse & Barak, 1976). One hundred and twenty-seven undergraduates were asked to view the same films of Perls, Rogers, and Ellis. The ability of the CRF to differentiate the factors of expertness, attractiveness, and trustworthiness was supported. Using the split-half method to determine internal consistency reliability, the authors found that while there was moderate overlap on some dimensions, the scales were reliable indications of perceived counselor dimensions.

In a field study designed to compare the differential perceptions of counselors' expertness, attractiveness, and trustworthiness, Barak and LaCrosse (1977) used clients', counselors', and observers' ratings of counseling sessions. A 3 x 3, two-factor repeated measures analysis was carried out on the CRF ratings of 19 clients at the student consultation service at Ohio State University who were seen by graduate counseling students. Results indicate that all three sources perceived the counselor dimensions of expertness, attractiveness and trustworthiness.

Several studies have related scores of the CRF and other indicators on client satisfaction or improvement. Barak and Dell (1977) conducted two studies which were designed to examine the effects of perceived counselor expertness, attractiveness, and trustworthiness and clients

willingness to refer themselves for help. Both studies used videotapes of male counselors and used undergraduate students ($N=69$; $N=73$). The first study manipulated the counselors' experience level (low and high) while the second study introduced a baseline experience level (immediate). Each study had the subjects view the first 10 minutes of the counseling videotape and had the subjects fill out the CRF and a self-referral questionnaire. The results of both studies indicate a positive correlation between the magnitude of the perceived counselor attractiveness, expertness and trustworthiness and the rate of self-referral.

Cash, Kehr, and Salzbach (1978) studied clients' help-seeking attitudes, perceived counselor source characteristics, and counseling outcome. The researchers randomly selected tapes (which depicted male and female counselors counseling with a confederate client) and showed them to groups of undergraduates ($N=219$ females). Initially, subjects were asked to fill out the Attitudes Toward Seeking Professional Help Scale. After viewing two 16-minute videotapes of a counseling session, subjects completed (1) two modified CRF inventories designed to determine perceived counselor expertness, attractiveness, and trustworthiness, (2) the BLRI (Barrett-Lennard, 1962), (3) a scale measuring their optimism of the client's continuing with the taped counselor, (4) a scale determining the likelihood of the client's returning for additional counseling, and (5) a scale assessing the subject's degree of confidence in the counselor helping with 15 specific types of problems. Using a correlational analysis, the authors found that counselors seen

as having expertise and trustworthiness dimensions would more likely have the client return and have a favorable counseling outcome.

LaCrosse (1980) conducted a field study in which pre- and post-data on the CRF and Global Attainment Scale (GAS) were obtained from 36 drug abuse clients (8 females and 28 males). The GAS is a method of obtaining specific, observable and quantifiable goals for clients despite individual, highly personalized goals (Kiresuk & Sherman, 1968). Utilizing correlational analysis, the author found that higher GAS scores were related to the magnitude of perceived counselor expertness, attractiveness, and trustworthiness.

Finally, in a study by Heppner and Heesacker (1983) the relationship of perceived counselor characteristics and client satisfaction was examined. Also considered was the effect of actual counselor experience levels on perceived counselor expertness, attractiveness, and trustworthiness. This field study used 72 undergraduates (48 females and 24 males) who sought counseling services at a university. The researchers had the subjects fill out the Expectations About Counseling Questionnaire prior to counseling. At the end of the semester, subjects filled out the Counselor Evaluation Inventory and the CRF. The results of correlating clients' expectations with perceived counselor characteristics and clients' satisfactions demonstrate that the clients' expectations about counseling were related to their perceiving counselors as expert, attractive and trustworthy.

Facilitative Conditions

In 1957 Rogers introduced his theory of "the necessary and sufficient conditions of therapeutic personality change" which provided a comprehensive and systematic conception of the basic change producing ingredients of the therapy process (p.1). Barrett-Lennard (1962) took a different approach to Rogers' (1957) theory. He claimed the client's experience of the therapist responses, rather than the experience of the therapist, influenced the therapeutic relationship. Barrett-Lennard took as his logical presumption that it was what the client personally experienced that affected the client directly. It followed from this that the relationship, as experienced by the client (rather than by the therapist), would be most crucially related to the outcome of therapy. Although it was not supposed that a client's conscious perceptions represent the personal experiencing of the therapist with complete accuracy, it is believed that the client's own report, given under suitable conditions, will be the most direct and reliable evidence of the client's actual experience.

Barrett-Lennard Relationship Inventory

The Barrett-Lennard Relationship Inventory (BLRI) was designed by Barrett-Lennard (1962) to yield measures of five facilitative conditions of the therapists' responses: empathic understanding, congruence (genuineness), level of regard (acceptance), unconditionality of regard, and willingness to be known. (The last two conditions are not discussed

at length as they are not variables of interest in the current investigation.)

The BLRI items were developed to ensure that they could be safely regarded as either positive or negative expressions of the variable that they were designed to represent. A formal content validation procedure was carried out on bi-polar adjectives. Five judges classified each item pair as either a positive or a negative indicator of the variable in question, and gave a neutral 0 rating to any item that was regarded as irrelevant or ambiguous. Judges also rated the strength of importance as positive or negative indicators of the variable on a -5 to +5 scale. The mean ratings for the items, from the five judges, were used in selecting the two half samples of items for split-half reliability assessment.

There was perfect agreement between judges, at the level of classing an item positive or negative, on all but four items. Three items were eliminated as a result of the poor ratings and three items were eliminated as a result of content duplication.

An item analysis was then conducted, in connection with revising the BLRI for further research. The method used was to tabulate and compare the answers given to each item by the "upper" and "lower" half of the sample ($N=40$) divided in terms of scores on the variable to which the item belonged. In the final set of 85 items used in the scoring, each variable was represented by 16-18 items.

To establish validity and reliability, BLRI data were gathered from clients and from therapists after the first six therapy interviews,

after the 15th and the 25th interviews (for those who continued therapy for the necessary lengths of time), and at termination of therapy. The internal consistency of the five individual scales was assessed by the split-half method. Because of the small number of items used in each scale, and the intentional variation in their theoretical content and form, the two half-samples of items were selected to be as nearly equivalent as possible from a theoretical standpoint. In the investigator's judgment the items in one half were matched as nearly as possible in content with the items in the other half, and the halves were approximately balanced with respect to the judges' mean ratings of the theoretical weight or strength of items.

Using the Spearman-Brown formula, the reliability coefficients of the scales of concern are level of regard (acceptance), $r=.93$; empathic understanding, $r=.86$; and congruence (genuineness), $r=.89$. These figures are believed to indicate quite satisfactory internal reliability of the measures (Barrett-Lennard, 1962).

Several studies have used the BLRI and related the scores as indicators of clients' satisfaction or improvement in treatment. Earlier in this chapter, the research of Tinsley and Harris (1976) and Tinsley, Workman, and Kass (1980) regarding clients' expectations about counseling were discussed. The results of each study found strong client expectations for the dimensions of social influence (attractiveness, expertness, and trustworthiness) and strong expectations for the dimensions of the facilitative conditions of genuineness, acceptance, and empathy.

In another study, LaCrosse (1977) hypothesized that significant positive correlations would emerge between perceived attractiveness and perceived empathic understanding and unconditionality of regard for clients', counselors', and observers' ratings. The results reported that observers and clients rated counselors significantly higher on each dimension of the CRF and BLRI than did counselors. This suggests the possibility of the presence of a strong common factor of perceived counselor behavior.

Additional studies have used the BLRI to establish a relationship between the facilitative conditions of acceptance, empathy, and genuineness with other beliefs about counselor effectiveness and clients change potential. In an investigation of timing and reciprocity of self-disclosure and reactions to an initial interview, Mann and Murphy (1975) interviewed 54 college females for 40 minutes about how they were influenced by friends, family, and persons in authority. The interviewer disclosed experiences, attitudes, and beliefs similar and dissimilar to those revealed by the student 0, 4, or 12 times during the interview. Such disclosures occurred prior to or immediately after the subject disclosures. Following the interview, the subjects were asked to fill out the BLRI. The results showed that an intermediate number of disclosures resulted in significantly more subjects' disclosures and led to the interviewer being described as significantly more empathic, warm, and congruent.

The study by Cash, Kehr and Salzbach (1978), described in detail in the social influence section of this review, examined the help-seeking

attitudes measure for research in counseling using the BLRI to study clients' perceptions of the facilitative conditions in counselor behaviors. The results indicate that there is positive correlation between favorable help-seeking attitudes and ascribing acceptance, empathy, and genuineness to the counselors' behaviors.

Both the Counselor Rating Form (Barak & LaCrosse, 1975) and the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) have been established as valid and reliable instruments in the examination of clients' perceptions of counselor characteristics. These instruments have also been used in studies examining relationships between counselor characteristics and client help-seeking, self-disclosure, goal setting and client satisfaction. Review of the literature and the use of these instruments supports their selection as evaluative instruments in this study.

Summary

Client expectations and perceptions, as discussed in the psychological literature, indicate that both the dimensions of social influence--attractiveness, expertness, and trustworthiness--and the facilitative conditions--acceptance, empathy, and genuineness--have a strong impact on therapeutic outcome. The CRF (Barak & LaCrosse, 1975) and the BLRI (Barrett-Lennard, 1962) are reliable and well developed instruments to measure these two concepts.

The literature also suggests that the issue of a co-therapy team versus an individual therapist is a matter of style and personal choice with no empirical evidence to support the choice of one modality over the other. Advantages and disadvantages within both modalities have been identified. Only one study to date has compared the use of a co-therapy team with the use of an individual therapist. In the teaching of behavioral problem-solving and communication skills to couples in therapy, no difference was found between therapist types in respect to outcome of the couples in treatment.

CHAPTER THREE METHODOLOGY

Research comparing the relative merits of individual therapy and co-therapy in marital therapy is lacking. A therapist's preference toward co-therapy or individual therapy appears to be based on personal choice, style, and trends. This analogue study examined the perceived effectiveness of an individual therapist versus a co-therapy team in conducting marital therapy. The effectiveness of the co-therapists and the individual therapist(s) was determined by the ratings made by a potential consumer population of their perceptions of the attractiveness, expertness, trustworthiness, acceptance, empathy and genuineness of the therapist(s) within each modality. Additionally, the potential consumer population gave overall ratings of the therapy session, their estimations of cost and identified the most and least important aspects of the therapy session.

Population

The population of interest for this study was men and women between the ages of 25 and 50, in the middle-socioeconomic class (defined here as equal to or greater than \$27,000 per household per year) (Bureau of Census, 1986), who had received no prior couples counseling.

The socioeconomic class of the potential consumer was an important component of this study as most public agencies' fee for services are based on the consumer's household income and are offered on a sliding cost scale. In such counseling settings, assignment of a therapist to the client is most often accomplished through a therapist-rotation system, when a therapist has a particular interest in the "case," or the therapist has a vacancy in his or her case load. Consumers have little, if any, input into their personal choice of therapist. It is the population of individuals who have the financial flexibility to pay the higher, private practice fees that was of interest to this study as these individuals are able to make a personal choice of therapist(s) and/or therapeutic approach based on personal preferences, perceptions, and knowledge.

The age range selected for this study was based on the adult development theory of Levinson, Darrow, Klein, Levinson, and McKee (1978). They identify three primary transition periods within an adult's life that may have impacted this research. The years from 27 to 31 are viewed by Levinson et al. (1978) as a time of questioning one's initial life structures with a reassessment and revision of those life structures occurring during the 40's transition period. A further questioning of those new life structures occurs again during the 50's transition. Marmor (1975) reports some evidence of increased therapy seeking during the transition periods by both individuals and couples. These transition points may be particularly stressful for already troubled relationships. Marriages that may have been difficult, but

tolerable, are often perceived as unbearable during the review periods of one's life.

Therapy naiveté was also an important consideration used to identify a potential consumer population. A prior negative or ineffective therapy experience has the potential of negatively influencing the subjects' overall perception of therapy. Likewise, a positive therapy experience may encourage belief that "effective" therapy is performed in one particular manner.

Sample and Sampling Procedures

Fifty-three subjects who met the criteria of middle socioeconomic class, between the ages of 25 and 50 and who had no prior couples' or marital therapy experiences volunteered to participate in this study.

Thirty of the subjects were parents of P. K. Yonge Laboratory School students who volunteered to attend a workshop for enriching family communication skills. Brochures advertising a 2 1/2 hour workshop offered free of charge in exchange for their participation in doctoral dissertation research were taken home by the student in grades K-6 (a copy of the brochure is located in Appendix A). Three dates were identified when the workshop would be offered and parents were requested to register in advance ranking date of attendance preference. A deadline date for registration return was set and the investigator picked up the registration forms from the central office and checked with each

classroom teacher. A total of 48 parents registered to attend the workshops.

Prior to registration of subjects the three dates for each workshop were randomly assigned a different therapy modality (1st session--co-therapy team, 2nd session--individual female therapist, 3rd session--individual male therapist). When the brochures were collected, the parent's first preference date of attendance was granted.

Each registrant was called to confirm registration and attendance to the workshop and called again the day before each workshop and reminded of the time and location. Parents who did not attend on the assigned date were called and offered the option of attending one of the other sessions. A total of 30 of the 48 registered subjects from P. K. Yonge Laboratory School attended the workshop and participated in this study. Nine individuals attended the first session, 8 attended the second session and 13 attended the third session.

All respondents were assigned to a group. Demographic information was collected at each workshop which identified those participants who did not meet the set criteria. To prevent embarrassment, all those who attended the workshop participated in the study; four responses from those who did not meet criteria were excluded later from the study by the investigator.

The participant number was insufficient to carry out this study and another group who would meet the set criteria was sought. Contact was made to the President of the Employee's Association at the V. A. Medical Center in Gainesville, Florida. Again, three dates were set and

each date was randomly assigned a different therapy modality (1st session—female therapist, 2nd session—male therapist, 3rd session—co-therapy team). Rather than offering a workshop, arrangements were made for the investigator to offer lunch to employees who met the set criteria in exchange for their participation in a doctoral dissertation study. An advertisement was circulated to departments believed to meet the family income minimums (dental, library, nursing, dietary, and engineering). These V. A. employees are allowed 30 minutes for lunch and two luncheons for each date were offered. Attendance was limited to 14 for each session. A total of 38 individuals attended lunch and participated in the study. There were 8 subjects attending the first session, 14 attending the second session, and 16 who attended the third session.

Investigation of the demographic sheets after the data collection, indicated that 11 participants did not meet the necessary criteria for subjects and their responses were excluded from the study. The final subject pool consisted of 53 subjects. There were 17 participants in the co-therapy group, 18 participants in the individual male therapy group and 18 participants in the individual female therapy group.

Independent Variable

The independent variable for this study was the form of marital therapist which has three levels: co-therapy, individual therapy by a male therapist, and individual therapy by a female therapist.

The three levels of therapist were presented in this study through the use of three videotapes of a marriage therapy session, one videotape per level. The color videotapes were recorded by the investigator and staff members of the media center using the video equipment and studio in the College of Education, University of Florida.

A tapescript of an actual conjoint marital therapy session was first obtained. Two therapists from the Corner Drug Store (an agency for alcohol and substance abuse clients) and their clients gave permission to use a videotape from an actual counseling session as the model for the development of the research stimuli tapes for this study. The therapists were mental health counselors trained and clinically supervised in strategic marital therapy techniques, the therapeutic approach to be demonstrated on each videotape.

An 18-minute segment of this session, which had a high interaction frequency between the clients and the clients and therapists, was selected from the actual counseling session to use as the script for each of the three research videotapes (a copy of the final script is located in Appendix B). A brief introduction and background information about the couple and what brought them to therapy were added to the beginning of each videotape. The final length of each tape was 20 minutes.

The script was enacted by a male adjunct faculty member and a female doctoral student who portrayed the marital therapists, and by two student actors, a male and a female, who portrayed the couple in therapy. Three videotapes identical to each other in content and

behavior were recorded; only the modality of delivery was changed. One videotape was an individual male therapist working with the marital couple, one videotape was the individual female therapist working with the marital couple, and one videotape was the same male and female therapists working as co-therapists with the marital couple.

To establish the consistency and content validity of each of the tapes, 20 graduate students from the Counselor Education Department of the University of Florida specializing in marriage and family therapy viewed and rated the videotapes. The graduate students viewed all three videotapes but rated each one individually after viewing. The student reviewers were asked to rate the representatives of each tape as typical of an individual or co-therapy session in marital therapy. They were also asked to select the type of theory-based therapy being conducted in each therapy session. Following the third videotape rating, the student reviewers' were also asked to rate the three videotapes with respect to the identicalness of content and therapist's behaviors.

Percentages of agreement were computed for each rating. There was 95% agreement among the student reviewers that strategic therapy was the marital therapy demonstrated in the three videotapes. There was 80% agreement that the videotape with both the male and the female therapists represented co-therapy and 90% agreement that both the male and female tapes represented the individual therapy approach. The student ratings were in perfect agreement (100%) that the three videotapes were identical in content and 90% agreement that the therapist behaviors were identical across the three videotapes.

Dependent Variables

The dependent variables were the potential consumer's perceptions of acceptance, attractiveness, empathy, expertness, genuineness, and trustworthiness. The instruments selected to measure these variables were the Revised Barrett-Lennard Relationship Inventory (BLRI) (Strong, Wambach, Lopez, & Cooper, 1979) and the Counselor Rating Form (CRF) (Barak & LaCrosse, 1975). Both instruments (using a paper and pencil approach) were designed to solicit information about the client's (consumer's) perceptions of the therapist(s). A brief evaluation questionnaire (Attachment C) was developed by the investigator which asked each subject three additional questions pertaining to overall effectiveness, cost, and specific advantages and disadvantages of each modality as perceived by the consumer.

Perceptions of Social Influence

The CRF (Barak & LaCrosse, 1975) was used to measure the perceived attractiveness, expertness, and trustworthiness of the therapist(s). This instrument was developed from the view of therapy as a social influence process developed by Strong (1968) who stressed that the success of therapy is greatly influenced by the consumer's perceptions of the therapist and not the actual therapist's characteristics. The CRF is an instrument of 36 paired bi-polar adjectives spread on a 7-point scale, e.g., #1 (attractiveness) "agreeable-disagreeable." There

are 12 items for each dimension measured with a range of scores for each dimension from 12-84. LaCrosse and Barak (1976) used the split-half method to determine internal consistency reliability and the ability of the CRF to differentiate the factors of attractiveness, expertness and trustworthiness which was supported. Data on the CRF suggest that it is a reliable instrument that has been used in a number of counseling studies to assess perceptions of counselor behavior on clients' willingness to refer themselves for help, clients' help-seeking attitudes, and client's counseling satisfaction and to compare counselor, client, and supervisor's perceptions (Barak & Dell, 1977; Barak & LaCross, 1977; Cash, Kehr, & Salzbach, 1978; Heppner & Heesacker, 1983; LaCrosse, 1977, 1980; LaCrosse & Barak, 1976).

Perceptions of Facilitative Conditions

The Revised Relationship Inventory (Strong, Wambach, Lopez & Cooper, 1979) was used to measure the consumer's perceptions of acceptance, empathy, and genuineness. The original 92-item Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) was based on Rogers' (1957) viewpoint that there were "necessary and sufficient conditions" experienced and communicated by the therapist that influenced therapeutic personality change, but tempered with Barrett-Lennard's own general belief that the client's experience of the therapeutic response is the "primary locus" of therapeutic personality change. The revised BLRI consists of 36 statements about the therapists to which the client responds with level of agreement on a 7-point scale

ranging from mostly disagree to mostly agree, e.g., #1 (empathy) "The counselor wanted to understand how I saw things." The statements are presented in both a positive and negative format, which is compensated for in the scoring procedures. There are eight statements for each dimension, measured with a range of scores from 7-56 for each. While the BLRI also included a 4-item scale to measure resistance and an 8-item scale to measure unconditionality of regard, data from these dimensions were not included in the study as they were not variables of interest.

The split-half procedure was used to determine internal consistency of the revised BLRI with internal consistency reliabilities reported as empathy, $r=.61$; level of regard (acceptance), $r=.81$; and congruence (genuineness), $r=.82$ (Strong, Wambach, Lopez, & Cooper, 1979). A number of research studies have used the BLRI to examine perceptions of the empathy, acceptance, and genuineness within a given situation or circumstance. This instrument has been used in several studies to assess the client's perception of the facilitative conditions on self-disclosure, help-seeking attitudes, procrastination, attractiveness, and the client's motivation to change (Cash, Kehr, & Salzbach, 1978; Mann & Murphy, 1975; Strong, Wambach, Lopez & Cooper, 1979; Vargas & Borkowski, 1982).

Experimental Design

This analogue study, a videotaped, simulated counseling session in which the reviewers react as though they are actually the participants, employed a post-test-only design. Each level of treatment was presented at P. K. Yonge Laboratory School and the V. A. Medical Center. The design is presented in Figure 1.

X_C	O_1
X_M	O_2
X_F	O_3

Figure 1. Co-therapy versus individual therapy post test design. (X=treatment, i.e. videotape viewed; C=co-therapy team, M=individual male therapist, F=individual female therapist, O=test observations).

Procedures

At each of the three workshops on marital and family communications skills held at P. K. Yonge and the six luncheon sessions held at the V. A. Medical Center, each participant was given an information packet. Each packet contained an Informed Consent Form (Appendix D), a demographic information form (Appendix E), a Revised Barrett-Lennard Relationship Inventory, a Counselor Rating Form, the brief evaluation questionnaire, and a pen. Each piece of information with the exception

of the Informed Consent Form was coded with a number and a letter to identify the videotape being reviewed while still insuring confidentiality. The subjects were welcomed and asked to read and sign the informed consent forms, which were collected before additional information was presented. The subjects were asked to complete the demographic information form before further instructions were given regarding the videotapes and the completion of the assessment instruments. Participants were asked if there were any questions before the treatment began.

After viewing the videotape, the subjects completed the instruments and placed them in the packets, sealed them and returned them to the investigator. Following a short break, the workshops at P. K. Yonge were then conducted.

Hypotheses and Research Questions

This study proposed the following research hypotheses:

1. There is no difference in potential consumers' perceptions of social influence among the male therapist, female therapist, and co-therapists in strategic marital therapy.
 - a. There is no difference in potential consumers' perceptions of expertness among the male therapist, female therapist, and co-therapists in strategic marital therapy.
 - b. There is no difference in potential consumers' perceptions of trustworthiness among the male therapist, female therapist, and co-therapists in strategic marital therapy.

- c. There is no difference in potential consumers' perceptions of attractiveness among the male therapist, female therapist, and co-therapists in strategic marital therapy.
- 2. There is no difference in potential consumers' perceptions of facilitative conditions among the male therapist, female therapist, and co-therapists in strategic marital therapy.
 - a. There is no difference in potential consumers' perceptions of acceptance among the male therapist, female therapist, and co-therapist in strategic marital therapy.
 - b. There is no difference in potential consumers' perceptions of empathy among the male therapist, female therapist, and co-therapist in strategic marital therapy.
 - c. There is no difference in potential consumers' perceptions of genuineness among the male therapist, female therapist, and co-therapists in strategic marital therapy.

In addition, the study was designed to answer the following research questions:

- 3. Is individual or co-therapy rated as more helpful by a potential consumer population?
- 4. What are the differences the potential consumer population will perceive in cost for individual and co-therapy?
- 5. What factors will a potential consumer population isolate as being most important and least important to clients in a marital therapy session?

Data Analysis

Two multivariate analyses (MANOVA) applying Wilks' lambda tests were conducted to analyze the data collected from the Revised BLRI and the CRF. This statistical method was selected because this study involved the examination of three levels of a single independent variable (form of therapy) and the use of two criterion measures with three potentially correlated scales for each. Conducting two multivariate analyses, rather than six univariate analyses, protected against the high probability of committing a Type I error (Huck, Cormier, & Bounds, 1974). Use of the MANOVA dictated that for any univariate analysis of variance (ANOVA) test to be considered significant, the corresponding multivariate test must first prove significant. The Wilks' lambda criterion was used to test the null hypotheses with significance level of .05 selected to reject the null hypotheses. To answer research questions three and four, chi-square analyses were computed to determine if there was a relationship between level of helpfulness and modality and if there was a relationship in perceived cost of therapy and modality.

CHAPTER FOUR RESULTS

This study examined perceptions of consumers by comparing an individual therapist and co-therapy team approach to strategic marital therapy. This chapter includes a description of the final sample, a discussion of each hypothesis and research question, and a summary of the results.

Sample

A total of 68 individuals initially viewed the marital therapy videotapes and responded to the questionnaires. However, 15 individuals who (1) did not meet the minimum family income or age range, (2) had been involved in couples counseling, or (3) left incomplete sections on the questionnaire were eliminated from the study. The final sample was comprised of 53 subjects who ranged in age from 27 to 50 years, with a mean age of 36.8 years. The subjects' annual income range was from \$27,000 to \$100,000 (per household), with a mean annual income of \$41,000. None of the subjects in this study had previous or current experience in couples counseling.

Thirty-four (64%) of the subjects of this study were female and 19 (36%) were male. In respect to race, 49 (93%) subjects were white and 4 (7.1%) were black. In this study, 47 (89%) of the subjects were

currently married and 10 (11%) were single. The number of years married ranged from 0-29, with a mean of 11.7 years married. Twenty-one (40%) of the subjects identified their religious affiliation as Protestant, 15 (28%) Catholic, 3 (6%) Jewish and 1 (2%) Holiness.

Hypothesis Number One: Social Influence

A multivariate analysis of variance (MANOVA) was conducted to address hypothesis number one, which stated that there is no difference in potential consumers' perceptions of social influence among the male therapist, female therapist and co-therapists in strategic marital therapy. In this analysis the three Counselor Rating Form subscales, attractiveness, expertness and trustworthiness, were treated as multiple measures of social influence.

The MANOVA procedure removed all subject observations that contained missing information. A final sample of 48 observations was used in the analysis of the overall effect of type of modality on perceptions of attractiveness, expertness, and trustworthiness. An inspection of the results of the MANOVA revealed no significant difference among the individual male, individual female and the co-therapy team, $F(6,86)=1.6$, $p=.153$, in respect to perceptions of social influence. Thus, the null hypothesis is not rejected. The source table for this analysis is located in Table 1.

Table 1
Source Table for the Multivariate Analysis of
Social Influence

Source of Variation	df	F	p
Marital Therapy Modality	6	1.6	.153

Multivariate Analysis of Variance

Source of Variation	SS	df	MS	F	p
Expertness					
S	1625.4105	2	812.7053	2.79	.0719
Error	13096.5061	45	291.0335		
Trustworthiness					
S	1190.4331	2	595.2165	2.22	.1198
Error	12038.5670	45	267.5237		
Attractiveness					
S	571.0703	2	285.5352	1.48	.2383
Error	8676.4088	45	192.8091		

While a lack of a significant multivariate analysis precludes reporting the separate univariate analysis, it should be noted that the analysis of perceptions of expertness approached significance, $F(2,45)=2.79$, $p=.0719$. The cell means and standard deviations of the Counselor Rating Form dimensions are presented in Table 2.

Table 2

Cell Means and Standard Deviations of the Counselor
Rating Form Dimensions Presented by Marital Counseling Modality

Modality	n	Mean	S.D.
Co-therapy			
Attractiveness	17	55.8	12.9
Expertness	17	58.8	16.4
Trustworthiness	16	61.7	13.0
Female Therapist			
Attractiveness	17	49.5	15.9
Expertness	17	46.9	18.1
Trustworthiness	17	53.5	18.2
Male Therapist			
Attractiveness	18	49.2	13.1
Expertness	18	48.5	16.8
Trustworthiness	17	50.2	16.4

Hypothesis Two: Facilitative Conditions

A MANOVA analysis was also conducted to address hypothesis number two, which stated that there is no difference in potential consumers' perceptions of facilitative conditions among the male therapist, female therapist, and co-therapists in strategic marital therapy. A final sample of 50 complete observations was used in the analysis of overall effect of type of modality on perceptions of acceptance, empathy and genuineness. An inspection of the results revealed no significant difference among the individual male, individual female and the

co-therapy team, $F(6,90)=.53$, $p=.7845$, in the perceptions of facilitative conditions as measured by the Revised Barrett-Lennard Relationship Inventory. Again the null hypothesis can not be rejected. The source table for this analysis is in Table 3.

Table 3
Source Table for the Multivariate Analysis of
Facilitative Conditions

Source of Variation	df	F	p
Marital Therapy Modality	6	.53	.7845

Univariate Analysis of Variance

Source of Variation	SS	df	MS	F	p
Acceptance					
S	13.2179	2	6.6090	.10	.9082
Error	3218.1621	47	68.4715		
Empathy					
S	278.2756	2	139.1378	1.31	.2798
Error	4996.5444	47	106.3095		
Genuineness					
S	250.8800	2	125.4400	.93	.4004
Error	6316.9000	47	134.4021		

The lack of a significant multivariate analysis precludes reporting the separate univariate analysis. The cell means and standard deviations of the Revised Barrett-Lennard Relationship Inventory are presented in Table 4.

Table 4
Cell Means and Standard Deviations of the Revised
Barrett-Lennard Relationship Inventory Dimensions Presented by
Marital Counseling Modality

Modality	n	Mean	S.D.
Co-therapy			
Acceptance	16	35.0	8.8
Empathy	16	34.5	9.6
Genuineness	17	32.7	11.2
Female Therapist			
Acceptance	18	34.7	8.0
Empathy	17	28.0	10.0
Genuineness	18	39.3	12.4
Male Therapist			
Acceptance	18	34.5	7.8
Empathy	18	29.0	11.3
Genuineness	17	39.1	10.9

Other Consumer Responses

This study was also interested in three other indicators of a potential consumers' preference for therapy. Participants were asked to rate perceived helpfulness, to estimate cost and also to list the most

and least important aspects for the clients in the videotaped counseling session they viewed. A total of 53 responses were used to compute a mean score for each rating.

Research question number three asked the subjects to rate the therapist(s)'s level of helpfulness to the couple on the videotape they viewed. They were given a seven point scale that ranged from 1 (very unhelpful) to 7 (very helpful). One subject wrote in a 0 which was included in the data analysis. The mean score for the co-therapists was 4.0 (neutral--neither helpful nor unhelpful), the mean score for the female therapist was 3.2 (slightly unhelpful), and the mean score for the male therapist was 2.6 (unhelpful).

A chi-square analysis was conducted to determine a relationship between helpfulness and modality of treatment. With ratings from 0-7 (very unhelpful to very helpful) the chi-square analysis for helpfulness resulted in a near significant difference among the three modalities, $\chi^2(14)=22.573$, $p=.068$. Through examination of the higher levels of helpfulness (levels six and seven), the co-therapists and the individual female therapist appear to have been perceived as more helpful by the potential consumers. The frequencies of each modality for each level of helpfulness ratings are summarized in Table 5.

Research question number four asked the subjects to select what they believed would be the fee for the videotaped therapy session they viewed. The choices ranged from \$25 to above \$75, increasing in increments of \$10 (there was a write-in of \$0 which was included in the

Table 5
Chi-square Analysis of Level of Helpfulness
by Marital Therapy Modality

Level of Helpfulness	Modality			Row Total
	Co-therapist	Female	Male	
0	0 0.00	0 0.00	1 100.00	1
1	0 0.00	3 37.50	5 62.50	8
2	4 28.57	6 42.86	4 28.57	14
3	5 55.56	1 11.11	3 33.33	9
4	0 0.00	3 100.00	0 0.00	3
5	2 28.57	1 14.29	4 57.14	7
6	5 50.00	4 40.00	1 10.00	10
7	1 100.00	0 0.00	0 0.00	1
Column Total	17	18	18	53

data analysis). The average fee indicated for the co-therapists was \$45, the female therapist, \$35, and \$45 for the male therapist.

A chi-square analysis was conducted to examine the association between perceived cost and each marital therapy modality. The perceived cost was based on a range from \$0 to above \$75. The chi-square analysis found no significant difference in perceived cost across the three levels of modality, $\chi^2 (14)=12.386$, $p=.575$. The frequencies for each modality for each level of perceived cost are presented in Table 6.

These results must be viewed with caution. It should be noted that for both chi-square analyses the number of observations per cell were too small to reveal any true or significant differences in helpfulness or cost in relation to the modality of marital therapy videotape viewed.

Research question number five asked the participants to identify what they believed to be the most and least important aspects for the clients in the videotaped marital therapy session. A list of the subjects' responses of the most important aspects and a frequency count for each response by modality are presented in Table 7.

Across all modalities, participants most frequently identified providing an opportunity for the couple to openly express their point of view and their feelings as being important to the couple in treatment. Participants also identified providing an opportunity for the couple to talk over the problem, to make a specific plan and the therapist(s) reminding the couple of their love and support for each other as important aspects of the therapy session.

Table 6
Chi-square Analysis of Perceived Cost by
Marital Therapy Modality

Perceived Cost	Modality			
	Co-therapist	Female	Male	Row Total
0	0 0.00	1 1.89	1 1.89	2
\$25	4 30.77	6 46.15	3 23.08	13
\$35	2 22.22	3 33.33	4 44.44	9
\$45	5 41.67	4 33.33	3 25.00	12
\$55	3 37.50	3 37.50	2 25.00	8
\$65	2 50.00	0 0.00	2 50.00	4
\$75	0 0.00	0 0.00	3 100.00	3
Above \$75	1 50.00	1 50.00	0 0.00	2
Column Total	17	18	18	53

Table 7

Frequency Distribution of the Most Important Aspects
of the Videotaped Marital Therapy Session for the Clients

Comment Categories	Modality					
	Co-therapists		Female		Male	
	#	%	#	%	#	%
Allowed open communication and expression of feelings	12	78	10	60	13	72
Provided opportunity to talk over problem and make plan	3	18	5	30	3	17
Brought to awareness that brother had changed (or come between) their relationship	2	12	5	30	1	5.6
Provided someone to listen to them	1	6	1	6	0	0
Reminded couple of their love and support for each other	4	24	4	24	1	5.6
The session was ended positively	0	0	1	6	0	0
Brought about recognition of other family obligations	2	12	2	12	0	0
Allowed couple to see other's point of view	1	6	0	0	4	22
Brought to awareness the need to work as a couple	1	6	1	6	1	5.6
Couple believed therapist(s) understood them and their feelings	1	6	0	0	1	5.6

A similar list of subject responses regarding the least important aspects of the marital therapy session was compiled. The list of the subject responses of the least important aspects for the clients is located in Table 8.

The participants identified that too much time was spent trying to determine how long the brother would be allowed to stay with the couple. Also perceived as not helpful to the couple was the excessive attention given to "what if" and other potential family crises and irrelevant remarks made by the therapist(s).

Summary

The statistical analysis of the data from this study of marital therapy modality failed to reject the null hypothesis that there is no difference in the perceived social influence dimensions of attractiveness, expertness and trustworthiness among an individual male, individual female, and co-therapy team in strategic marital therapy by a potential consumer population. The study results also indicated no difference in the perceived facilitative conditions of acceptance, empathy and genuineness among an individual male, individual female and a co-therapy team in strategic marital therapy by a potential consumer population. However, examination of means and cell frequencies suggests a possible difference among modalities specifically in the areas of expertness and perceived level of helpfulness with co-therapists seen as

Table 8

Frequency Distribution of the Least Important Aspects
of the Videotaped Marital Therapy Session for the Clients

Comment Categories	Modality					
	Co-therapists		Female		Male	
	#	%	#	%	#	%
Too much time spent determining how long brother would stay	3	18	2	12	4	22
Too much attention on "what if" and other possible family problems	4	24	4	24	6	33
Couple made no decisions or got any answers—they were still confused	2	12	1	6	2	11
Therapist(s) asking how they could show love for each other	0	0	1	6	0	0
Wife was left out at end of session	1	6	1	6	0	0
Therapist(s) made irrelevant remarks	1	6	3	18	3	17
Therapist(s) was inept	2	12	2	12	3	17
Therapist(s) said this was a way husband could test his wife's love	0	0	0	0	1	6
Therapist(s) left the room—couple left alone	2	12	0	0	0	0
Couple were dependent on therapist(s) to solve problem	1	6	0	0	0	0

more expert and co-therapists and the individual female therapist perceived as more helpful.

CHAPTER FIVE DISCUSSION

This analogue study was designed to test possible differences between an individual therapist and a co-therapy team approach to marital therapy as perceived by a potential consumer population. This study examined the modality preference of consumers in respect to the social influence dimensions of attractiveness, expertness and trustworthiness and the facilitative conditions of acceptance, empathy and genuineness. Also of interest were potential consumer's perceptions of cost, helpfulness and the important and unimportant aspects of the counseling session.

Discussion of the Results

This study found no significant differences in consumer perceptions of the three therapy modalities. In general, the results of this investigation parallel the findings of an earlier comparison study of modality in marital therapy by Mehlman, Baucom and Anderson (1983). Using marital behavior therapy techniques and clients as subjects, Melham et al. found no difference in the improvement of the maritally distressed couples seen by an individual therapist and the improvement of those maritally distressed couples seen by a male-female co-therapy team. In this investigation strategic marital therapy techniques were

used and potential consumer's perceptions of modality preference were examined. Neither study found significant differences between the individual therapy and co-therapy approach.

Melham et al. (1983) suggest that the lack of significant difference in their study of modality may be attributed to the skills-oriented treatment approach of behavior marital therapy. They contend that once a therapist is proficient in teaching specific skills, the usefulness of an additional therapist contributes little to increase the effectiveness of treatment. Melham et al. state further that the usefulness of a co-therapy team may vary depending upon the treatment strategy being used.

In the current study the investigator believes the therapy employed may also be identified as responsible for lack of significant differences in treatment modality. Participants' responses to the research question asking for the least important aspects of the counseling session viewed suggest responses may have been made to the therapy rather than to the modality of treatment. There were four strategic therapy techniques that seemed to provoke consumer reaction: reframing, assigning a task, consulting with peers/supervisors, and struggle for power. During the videotaped counseling session the therapist(s) implemented the strategic tool of reframing by reidentifying the couple's tendency to be sharing and generous to others at the expense of their own well being as being "good samaritans." The therapist(s) also reframed the identified problem as a way the husband could test his wife's love for him. These, and other such reframing

statements, were identified by the participants as irrelevant remarks made by the therapist(s).

When the therapist(s) approached the process of assigning a task to the couple, the husband and wife were allowed to engage in dispute. Although the therapist(s) focused on how the couple disagreed, the participants responded that too much time was spent on "what ifs."

Another technique of strategic therapy allows the therapist(s) to leave the room and either plan with each other or to get feedback from a supervisor who has been observing the session either through a one-way mirror or on a t.v. monitor. This technique, too, was viewed negatively by participants.

Of final consideration here is the strategic therapy issue of power. Haley (1973) identifies strategic therapy as a power struggle between the couple and the therapist(s). Participants identified the therapist(s) pressing the couple for a time the brother would leave and pressing the husband for other alternatives as unhelpful to the couple in treatment.

These responses and the low ratings of helpfulness contribute to the speculation that the participants reacted to the therapy itself as well as to the therapist(s) conducting the session. Thus, their ratings of the therapist(s) could have been influenced by their general attitude toward the therapy. While this influence would be present in all modalities, it may have been of sufficient strength to overpower any real differences due to modality.

The investigator believes two other circumstances may be factors responsible for the lack of differences observed across the three modalities. One factor is that of the small number of participants in the study. Although each of the three groups of participants had slightly over the minimum number of subjects required for the statistical analysis, a larger number of participants in each group would have provided a more adequate base of information to test the hypotheses for differences between types of modality.

Finally, the participants had limited knowledge about the counseling process and in this study viewed only one videotape and responded to it. Perhaps an experimental method that would have allowed subjects to truly compare modalities, e.g., viewing several methods and rating them, would have helped the discernment of differences in modality.

While there were no significant differences found among the three modalities, several trends can be noted. There appeared to be an overall trend in favor of the co-therapy team approach which received the highest ratings across all dimensions of social influence, facilitative conditions, level of helpfulness and expected fee for service with exception only in the dimension for genuineness.

An interesting observation that warrants notation was the consumers' perceptions and evaluations of the individual male therapist. While the individual male therapist was given a low rating ($M=2.6$ —unhelpful) in level of helpfulness, he received a higher rating in perceived fee for service ($M=\$45$). On the other hand, the individual

female therapist received a higher rating of level of helpfulness ($M=3.2$ —slightly unhelpful) and a lower perceived fee for service ($M=\$35$). This information is similar to the findings reported by Dell and Schmidt (1976) that males are generally viewed as more expert by virtue of their sex and females more helpful.

Limitations

Although much deliberation and consideration went into designing this study to control possible contaminating and confounding variables, several limitations must be considered in interpreting these data and drawing conclusions.

The implementation of an analogue study design that utilized three 20-minute videotapes to represent strategic marital therapy in an individual male, individual female therapy approach and a male-female co-therapy team approach is one such limitation. Although these tapes were rated as valid representatives of individual and co-therapy approaches to marital therapy, they may not be representative of the entire marital counseling process. Of additional consideration is the nature of analogue studies. In this analogue study a simulation of a counseling session was presented and participants were requested to respond as though they were a client. There exist some questions as to the authenticity to which the responses are indeed how the participants would respond in a real life situation.

Another limitation is the composition of the consumer sample used in this study. Because the initial response to the family enrichment workshops was very low and the no show rate was over 50%, it is plausible that those individuals who did participate in the workshop were unique and may not be representative of the average consumer of private marital therapy services.

Implications

The results of this study did not reveal any differences among the three marital therapy modalities. While keeping in mind the study's limitations, the impact of the results on cost, time and the training of marital therapists is a worthy consideration to examine. Since no differences were noted among the modalities, using two therapists to conduct a marital therapy session may be considered a waste of resources. If clients are able to receive services from one therapist that are as effective and helpful as therapy received by a co-therapy team, using two therapists for one hour may not be the best use of that therapist or the therapeutic hour.

In a similar vein, no differences were revealed in the perceived cost of the therapy session across the three modalities. This may indicate that consumers may see no reasons for extra monetary compensation of an additional therapist. The average fees for both co-therapists and the individual male therapist were identical (\$45). This

may be an influential factor for private practice marital therapists considering co-therapy as a cost-effective approach.

There are also implications from this study in the area of training marital therapists. Considering the lack of difference found among the modalities presents the question of what is the most effective training approach. In light of the previously stated disadvantages of co-therapy, perhaps the greatest emphasis in training should be on individual development as a marital therapist. This training would focus on understanding the couple's process and developing and refining therapeutic skills, rather than complicating the learning process by introducing the complexities associated with co-therapy.

Recommendations for Future Research

There is a deficit of research in the area of marital therapy at large and particularly in respect to questions relating to therapy comparison of effectiveness and modality. Obtaining the potential consumer's perspective of effectiveness is a useful approach to this type of research. The consumer is a reasonable and likely source from which to gain information on the needs and types of services marital therapists might offer. With a 50% divorce rate among couples, there is much to learn from those who have experienced marital distress or divorce in the area of specific needs.

Although this study found no significant differences, the near significant difference in perceptions of expertness and the general

trend of higher ratings for co-therapy suggest replication of this study using a larger number of subjects. Further studies of the differences between individual and co-therapists must control for the effect due to therapy style. Control might be accomplished by using a more neutral therapy or a research design that allows the partialing out of the variance contributed by the therapy and the variance contributed by the therapist modality.

Summary

This analogue study, using a potential consumer population as subjects, found no differences among an individual male therapist, individual female therapist, and a co-therapy team in the social influence dimensions of attractiveness, expertness, and trustworthiness; the facilitative conditions of acceptance, empathy and genuineness; cost of therapy sessions; or level of helpfulness. There are, however, several near significant differences in perceptions that would suggest a potential consumer's preference for a co-therapy approach to marital therapy.

As there is some question that the subjects of this study may have been influenced by the intensity of strategic therapy itself, regardless of therapist modality, a more neutral therapy is suggested for replication and future research.

Based on this study's results of no difference in perceptions of different modalities, the use of an additional therapist in a marital therapy session may not be warranted. In addition, the investigator

suggests training of marital therapists' focus on the individual modality approach, allowing trainees to develop and refine their skills before creating a therapeutic relationship that potentially has its own adjustment problems.

Future research in marital therapy is crucial. Therapy comparison studies of the effectiveness and modality of therapy using consumer perceptions can make important contributions to and increase the credibility of marital therapy as a profession.

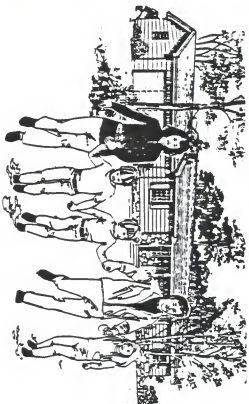
APPENDIX A
IMPROVING FAMILY COMMUNICATIONS AND
ENRICHING RELATIONSHIPS BROCHURE

Improving Family Communications

and

Enriching Relationships

THE SEMINAR WILL BE CONDUCTED BY
GLENDA ISENHOUR, M.ED., ED.-S., WHO
IS CURRENTLY COMPLETING HER DOCTORAL
STUDIES IN MARRIAGE AND FAMILY THERAPY
AT THE UNIVERSITY OF FLORIDA.
MS. ISENHOUR WORKED THREE YEARS FOR
BATTERED WOMEN'S SERVICES, INC. IN
NORTH CAROLINA AND HAS CONDUCTED
WORKSHOPS FOR TEACHERS, COUNSELORS,
AND SCHOOL PSYCHOLOGISTS THROUGHOUT
THE STATE OF FLORIDA. SHE ALSO WORKS
WITH COUPLES AND FAMILIES IN CRISIS.



THIS ONE EVENING SEMINAR WILL PRESENT,
IN AN INFORMAL AND RELAXED ATMOSPHERE,
DEMONSTRATION AND DISCUSSION OF
TECHNIQUES PARENTS CAN USE TO PROMOTE
BETTER UNDERSTANDING AND INCREASE
RESPECT AMONG FAMILY MEMBERS.

THE PURPOSE OF THIS TWO HOUR SEMINAR
INCLUDE:

- * DEVELOPING EFFECTIVE
COMMUNICATION BETWEEN PARENTS
AND THEIR CHILDREN, AND
BETWEEN PARTNERS
- * UTILIZING EFFECTIVE METHODS TO
DIFFUSE EXPLOSIVE FAMILY
SITUATIONS
- * LEARNING EFFICIENT METHODS
OF COOPERATIVE PROBLEM
SOLVING BETWEEN PARENTS AND
THEIR CHILDREN, AND BETWEEN
PARTNERS
- * ACKNOWLEDGING AND ACCEPTING
INDIVIDUALITY AMONG FAMILY
MEMBERS, YET NURTURING A
COOPERATIVE FAMILY ATMOSPHERE

FOR YOUR CONVENIENCE, THREE DATES HAVE
BEEN ARRANGED FOR THIS SEMINAR

DATES: APRIL 9, 1986
APRIL 10, 1986
APRIL 14, 1986

TIME: 7-9:30 P.M.

LOCATION: P.K. YONGE LIBRARY

THIS SERVICE IS PROVIDED FREE OF CHARGE
IN EXCHANGE FOR YOUR PARTICIPATION IN A
UNIVERSITY OF FLORIDA DOCTORAL RESEARCH
STUDY. YOU WILL BE ASKED TO VIEW AND
RATE A 20 MINUTE SEGMENT OF A MARITAL
THERAPY VIDEOTAPE.

PLEASE FILL OUT AND RETURN TO P.K. YONGE
BY FRIDAY, APRIL 5, 1986.

I AM INTERESTED IN ATTENDING THE
SEMINAR

NAME _____
(if both partners wish to attend,
please include both names)

PHONE NUMBER _____

DATE YOU WISH TO ATTEND (select two
in order of preference)

1. _____

2. _____

I AM NOT INTERESTED IN ATTENDING THE
SEMINAR

SPACE AVAILABILITY IS LIMITED AND ADVANCED
REGISTRATION IS NECESSARY. YOU WILL BE
CONTACTED BY PHONE AND YOUR REGISTRATION
CONFIRMED.

APPENDIX B
VIDEOTAPE SCRIPT

VIDEOTAPE SCRIPT

Introduction to Videotape I

The following is a re-enactment of an actual counseling session. In this segment we will be joining Carol and Wayne who are meeting with Linda and Tom, a marital counseling co-therapy team. Carol has initiated contact with the counselors by making the appointment. Her complaints are that the family difficulties began when her brother-in-law, Jim, moved into the house a few weeks ago. Jim has been under psychiatric care for the past 20 years and has been identified as schizophrenic. Although he wanted to start fresh in Gainesville, he has made no efforts to find work, has not contributed to the household and does not abide by the household rules. During this time Wayne has stopped attending classes at the University and has very little interaction with the family. Carol is expressing feelings of frustration and desperation to bring their lives back to normal. We join the couple midway through the counseling session.

Introduction to Videotape II

The following is a re-enactment of an actual counseling session. In this segment we will be joining Carol and Wayne who are meeting with Linda, a marital therapist. Carol has initiated contact with the counselor by making the appointment. Her complaints are that the family

difficulties began when her brother-in-law, Jim, moved into the house a few weeks ago. Jim has been under psychiatric care for the past 20 years and has been identified as schizophrenic. Although he wanted to start fresh in Gainesville, he has made no efforts to find work, has not contributed to the household and does not abide by the household rules. During this time Wayne has stopped attending classes at the University and has very little interaction with the family. Carol is expressing feelings of frustration and desperation to bring their lives back to normal. We join the couple midway through the counseling session.

Introduction to Videotape III

The following is a re-enactment of an actual counseling session. In this segment we will be joining Carol and Wayne who are meeting with Tom, a marital therapist. Carol has initiated contact with the counselor by making the appointment. Her complaints are that the family difficulties began when her brother-in-law, Jim, moved into the house a few weeks ago. Jim has been under psychiatric care for the past 20 years and has been identified as schizophrenic. Although he wanted to start fresh in Gainesville, he has made no efforts to find work, has not contributed to the household and does not abide by the household rules. During this time Wayne has stopped attending classes at the University and has very little interaction with the family. Carol is expressing feelings of frustration and desperation to bring their lives back to normal. We join the couple midway through the counseling session.

Linda and Tom: Co-therapists

Carol and Wayne: Couple in therapy

Linda But that's not your concern--your serious concern tonight. It's more what's going on in your own family.

Carol My family is a prime concern of mine and part of what is affecting my family right now--I feel is Jim. And part of it is that we don't agree on the way things should be and uh,

Tom What ways are those Wayne?

Wayne Ah, this is new to me. This has never been discussed since he came up.

Carol That's not true.

Wayne It is true.

Carol That is not true. (Stammering a bit) I said to you that--laying right there in bed with you--that this was not a time that I felt I could be supportive of Jim being here and that I, ah, was not--uh, I'd just gotten off the phone talking with your Mom. . .

Tom This is how many weeks ago?

Carol One week. Max.

Tom He's been here five weeks so it took you four weeks before you said you don't want him here.

Carol I didn't think he'd stay this long.

Tom Go ahead, Wayne.

Wayne I don't remember what the question was.

Linda Were you surprised that this is a problem for your wife?

Wayne No, I'm not surprised. I'm just saying it's just never really been discussed.

Carol (Angrily and frustrated) And when WOULD we discuss things? Just when I get to something Jim walks through or he's walking by the window.

Linda And you can't talk?

- Carol I don't even feel like I can make love. He's always sitting on the front porch or out in the living room. And I feel like I have to be quiet. It affects me or in my mind it affects me. I like my privacy. I don't like. . . . Maybe I'm a little more jumpy at night. I don't like to hear sounds--people walking around on the front porch and around. I've become more accustomed to it because I know it's Jim. I don't know. Maybe he's not the crux of the problem. Maybe it is really us. I don't know. I DON'T KNOW.
- Linda You just opened your door one day and there he was.
- Carol Oh yeah. Wayne was working nights and I was cleaning the living room. All of a sudden there was walking outside the house and there he was. He said he came up for a visit.
- Linda Did he have a lot of luggage and stuff?
- Carol No, it was all out in the car at the time. I thought he'd come up for a visit because up until that point in time he'd been working and we didn't know anything about it.
- Wayne I think that a lot of the animosity is because he's my brother. I think if it was one of your family members that it wouldn't be as intense for you.
- Linda She could make love with you if it were her own family?
- Wayne Well, I don't know about that.
- Carol I disagree with that.
- Wayne Well . . .
- Carol My family? My family? Who hasn't even. . . .
- Wayne That's not the point--if they had. . . .
- Carol That could be. I doubt it--it could be but I think you're wrong. Jim operates differently around you than he does me.
- Wayne That's probably true.
- Tom How do you mean?
- Wayne He probably behaves better when I'm around. I think that's what she means.
- Tom And how do you operate?

Wayne I don't know what you mean.

Tom Do you operate better or do you operate worse with Jim?

Wayne I don't know that there's a difference really.

Linda (To Carol) What would you answer to that?

Carol Well, for the last couple of weeks I think he's been more friendly with him than he is with me.

Linda But in general is he more fun? Is he. . . .

Carol It depends a lot on Jim's mood, too. If Jim's pensive or angry, uh, or very quiet, then that's the mood of the household. Or if Jim's in a good mood that helps or aids in, ah, the rest of the household.

PAUSE FOR A FEW SECONDS

Tom And you've been married how many years?

Wayne Ten years.

Tom A decade. And has the decade been a good one up until now—how long ago—a year?

Carol No, we've had our rough spots—you know. There's been parts of that decade that weren't all that great, but there's been a lot of that decade that has been good, too.

Tom See—I'm confused, you say you don't communicate but you seem to be communicating here.

Linda Yeah, really well—or do you just save this for therapy sessions?

Carol I think it's been saved 'til tonight.

Linda So what would you like to see happen with this situation with your brother?

Wayne Realistically?

Linda Idealistically—What would you like to see happen?

Wayne I'd like to see him out on his own—Happy somewhere.

- Carol I would too. I would love that. Just because I don't want him living in my house doesn't mean I don't wish him well. I would love that and on his own—so that his Mom and Dad don't have to deal with that, that situation and we don't have to deal with that situation. But I don't know if that will ever work out.
- Linda Well, I don't know you too well, but from what we've been talking about tonight, you seem like a good Samaritan and that you would be really unhappy if you couldn't be helping someone else out and you even open up your home. It's not just this brother—you've done this for other people, for families. I mean maybe you'd be really unhappy. I don't know. It's just a guess.
- So you'd like to see him living on his own and you'd like to see him on his own. So you both have the same ideal. Realistically, what can you see happening?
- Wayne Basically the same thing. I just don't believe he's capable of being on his own right now.
- Tom How many more weeks is it going to take before you get him ready?
- Wayne Well, I'm not working on getting him ready.
- Linda So, he's just going to stay forever?
- Wayne Well, the bottom line is, family is family—for me.
- Tom So, how many weeks does that mean that he might be there?
- Wayne I don't know, but there's not going to be a point well, where at six weeks you should be ready and you're out.
- Tom Christmas time—will he be there, you think?
- Wayne Ah, he could be.
- Tom When do you think he's be ready, if you were to take a guess?
- Wayne Well, I don't know. He's so erratic. You know, he's already left once since he's been here.
- Tom Ah—so he adds a lot of spice to your life by living there.
- Wayne Yeah, he does.
- Tom To your life or to your wife's life?

- Wayne Well, since we both live in the same house, I guess both of us. Maybe not in the same way but. . .
- Carol I don't think I understand "adds spice to your life," is there some kind of sarcasm there? I'm not certain I understand that—AT ALL.
- Tom Well, if you never know if this guy is going to be there or not—sounds like you never know what to expect.
- Linda It sounds pretty exciting to me.
- Carol Well, since the situation is about five weeks old—up until that time there was no consideration that he would be there. In other words, he was—at home—and . . .
- Tom Well, how many weeks do you think he'll stay there?
- Carol Well, obviously Wayne's just told me—until Jim decides to go home.
- Tom How long do you think that will be?
- Carol I have no idea.
- Tom Well, I'm a stranger and I've got a worse guess than either of you two guys. (To Carol) What would you guess?
- Carol I'm not going to guess. I have no idea.
- Tom How many more weeks will you let him—be willing for him to stay?
- Carol (Heavy sigh) I'm not willing to, ah, be, ah . . .
- Tom The evictor?
- Carol Yeah.
- Tom So he can stay there as long as he wants?
- Carol That's not the way I feel. I feel that there comes a time when you have to choose between your immediate family which is—basically when you get married, you form your own family and that is your priority. In other words, my family, ah, my family—they each have their own families—and Wayne and I are one. And I AM NOT going to sacrifice my family for them. You know, I'm not going to sell my house, um, I'm just not going to do THAT for THEM. Because I feel, first off that's

cheating my kids and that's cheating him. And I married him by choice—I was just born to them by chance.

Wayne What happens when Audrey dies from her cardiac problems and your father is well into Alzheimer's disease and he has to come to Florida to live with you. Are you going to set up a particular—"Well Dad can stay here for three months and then he's out or is he welcome because he's family?"

Carol (Pause) It would be the same as for your mother which we agreed upon and my mother—we would deal with the situation when it came. Uh, whether it was, they stay in a nursing home or they stay with us. I personally feel. . .

Wayne (Irritated) That's not my understanding at all.

Carol My feeling is that they should. . . . My ideas have changed. Before I always thought Wayne's Mom or Dad—if something happened they could just come and live with us. Well, my ideas have changed on that and now. . .

Linda You're not willing to be the good Samaritan anymore?

Carol I am willing to help out as much as I can, but there's a happy medium between the, uh, iffy picture you present and reality.

Wayne So, you would kick your father out, after three months?

Carol No, no I'm not telling you that at all. No.

Wayne Then you'd send him to a nursing home or whatever?

Carol No—not at all.

Wayne Well, what would you do?

Carol I'd analyze the situation. I would see what kind of income he has, where we're at, how it would affect our family, which I think would drastically change.

Wayne So, he's got no income and not able to live on his own. And your brothers and sisters are not willing to take him. Then what do you do with him?

Carol I don't know, just. . .

Wayne Do you kick him out in three months because his time is up or. . .

Carol (Angrily) I'm not saying a three month period of time.

- Wayne Well, I'm just using an arbitrary number. When you get tired of him you would throw him out?
- Carol I'm not so certain I would take him in in the first place.
- Wayne Oh give me a break! You can't be serious! You can't honestly believe that in your heart! You can't sit there and tell me you wouldn't take your father!
- Carol I don't know. I think he would be damaging to my family and I have. . .
- Wayne And you would not take your father? That's not possible!
- Carol No, that's probably true. So, what's the point?
- Wayne The point is—family is family (pause) the way I see it.
- Tom What would happen if you got real angry?
- Carol Me? Oh, I scream and yell.
- Tom Then what happens?
- Carol Oh, Wayne walks away.
- Tom And gets quiet for days?
- Carol Yeah, Wayne doesn't like that.
- Tom And then what do you do?
- Carol Well, I have a nasty habit, not nasty really, I have a habit of trying to initiate—I push, like "What's wrong?" "Don't you want to talk about it?" Things like that, um questions. When it's obvious he doesn't want to talk.
- Linda And that really bugs you?
- Carol If he's not ready to talk about it—he won't talk. But I'm ready and I want to talk about it right now, so. . .
- Tom and Linda pause a few seconds and then Tom says they will take a break.
- Tom Let's take a break to talk some.
- Linda All right. (Leave the room)

PAUSE ONE FULL MINUTE — Then return

- Linda We're going to try to summarize what's gone on here tonight. One of the things I want to say is I am really struck by how loyal both of you are and how caring you are for allowing this brother to live with you even though it creates a lot of stress for both of you.
- Tom to Linda It shows how much she loves him by allowing his brother, who has some kind of mental disorder to stay in their home. To put up with this kind of intrusion.
- Tom It would be kind of like me sitting over here. (Gets up, moves chair between couple) (to Wayne) Is it hard to let your wife know you love her like this?
- Wayne Ah, . . .
- Linda And it's because you're the caring, compassionate people that you are that you're allowing this to happen—for someone to be between the two of you.
- Tom How can you show your wife that you love her like this?
- Wayne (pause) I can't.
- Tom (to Carol) What about you—can you show him that you love him?
- Carol It would be hard.
- Tom (Starts to move back—hesitates) Do you want me to stay here or move over there?
- Carol Move over there.
- Tom You want me to get out from between the two of you?
- Carol Absolutely.
- Tom We were also talking about this being a way to test your wife's love for you. Maybe sometimes we need to go through a test—maybe not.
- Wayne The reverse of that is—To show Carol how much I love her, I throw my brother out?

- Tom All I'm saying is that right now—this is one way you can test your wife's love. And if you didn't love him you would not be dealing with this.
- Carol There's no question in my mind.
- Tom You're both very loyal.
- Linda And because you are so loyal—those loyalties make things tough for you. It's difficult to be loyal to everybody.
- Tom (Standing by Wayne) Ok, Wayne, how could you get Jim to leave the house—temporarily—to give you two some time?
- Wayne Well (pausing) He has plans to go to the Gainesville Singles Meeting next week.
- Tom Ok, that's what Jim can do. What can you do to get him out of the house?
- Wayne I don't know.
- Tom What other alternatives are there?
- Wayne Well, maybe, to get her out of the house.
- Carol Now we come to another big problem.
- Tom I'm sure Wayne can handle this.
- Wayne (Pause) Well, just for us to go for a ride.
- Tom Ok. That's a great idea. What else?
- Wayne Well, that's about all. I'm feeling a little pressure here to. . .
- Tom I'm not trying to pressure you.
- Wayne You are, too (Laughs, stands up). That feels better, more equal.
- Tom (To Carol) Well, Wayne's a man of action. I'm glad to see that. Here you are ready to face me head on.
- Wayne Right.
- Tom Is it alright for me to talk to your wife now?

Wayne Yeah, sure (sits down).

Tom (Turns to Carol) What would be your ideas?

FADE OUT.

APPENDIX C
EVALUATIVE QUESTIONNAIRE

EVALUATION QUESTIONNAIRE

1. Circle the level as to how you would rate this therapy session if you were one of the clients.

1 2 3 4 5 6 7

1 = very unhelpful

7 = very helpful

2. Check what you believe the fee for this therapy session would be.

_____ \$25

_____ \$55

_____ above \$75

_____ \$35

_____ \$65

_____ \$45

_____ \$75

3. What do you think were the most important points, for the clients, about this session?

What were the least important points for the clients?

APPENDIX D
INFORMED CONSENT FORM

University of Florida
Department of Counselor Education

Subject's Name _____

Subject's Address _____

Project Title Perceived Differences Between Individual and Co-
Therapists in Strategic Marital Therapy

Principal Investigator Glenda E. Isenhour, Ed.S. Date _____

Address 1215 Norman Hall, Gainesville, FL 32611 Phone 392-0731

I agree to participate in the research as explained below:

The aim of this study is to examine the perception's of a potential consumer population on different styles of marital therapy. This information will be used to make suggestions for future education and training of marital therapists. There is neither harm nor personal benefit from participating in this research study. To participate in this study, you will need to do the following things:

1. Complete the requested demographic sheet
2. View a 20 minute videotape of a marital therapy session
3. Complete three short information surveys about the videotapes.

Please feel free to ask any questions which you may have at this time.

The above stated nature and purpose of this research, including discomforts and risks involved (if any) have been explained to me. Furthermore, I understand that this investigation may be used for educational purposes which may include publication. I also understand that I may contact the principal investigator at the address or phone number above with questions or to withdraw my consent at any time without prejudice.

All information to be collected (questionnaires and information sheets) have been coded to provide maximum confidentiality. There is no link between the coded questionnaires and your identity. All other information will be kept confidential within legal limits (or to the extent provided by law).

I have read and I understand the procedure described above. I agree to participate in the procedure and I have received a copy of this description.

Signed _____

I have defined and explained fully this research to the participants whose signature appears above.

Signed _____

APPENDIX E
DEMOGRAPHIC INFORMATION

The demographic information requested below will be used solely for the purpose of this research project. No personal identifying information is requested to insure confidentiality.

DATE OF BIRTH _____

RACE _____ SEX _____

RELIGIOUS AFFILIATION _____

MARRIED _____ # OF YEARS _____

DIVORCED _____ WIDOWED _____ SINGLE _____

FAMILY'S APPROXIMATE YEARLY INCOME _____

HAVE YOU BEEN OR ARE YOU CURRENTLY IN:

Couples Counseling _____

Individual Counseling _____

Group Counseling _____

THANK YOU FOR YOUR PARTICIPATION.

REFERENCES

- Ackerman, N. (1966). Treating the troubled family. New York: Basic Books.
- Aponte, H., & VanDeusen, J. (1981). Structural family therapy. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 310-360). New York: Brunner/Mazel.
- Barak, A., & Dell, D. (1977). Differential perceptions of counselor behavior: Replication and extension. Journal of Counseling Psychology, 14, 288-292.
- Barak, A., & LaCrosse, M. (1975). Multidimensional perception of counseling behavior. Journal of Counseling Psychology, 22, 471-476.
- Barak, A., & LaCrosse, M. (1977). Comparative perceptions of practicum counselor behavior. Counselor Education and Supervision, 17, 202-208.
- Barak, A., Patkin, J., & Dell, D. (1982). Effects of certain counselor behaviors on perceived expertness and attractiveness. Journal of Counseling Psychology, 29, 261-267.
- Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 76, 1-36.
- Bodin, A. (1981). The interactional view: Family therapy approaches of the Mental Research Institute. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 267-309). New York: Brunner/Mazel.
- Boszormenyi-Nagy, L., & Spark, G. (1973). Invisible loyalties: Reciprocity in intergenerational family therapy. New York: Harper and Row.
- Bowen, M. (1966). The use of family theory in clinical practice. Comprehensive Psychiatry, 7, 345-374.
- Bureau of Census. (1986). Statistical abstract of the United States. Washington, D.C.: U. S. Department of Commerce.

- Carkuff, R. (1971). The development of human resources. New York: Holt, Rinehart, & Winston.
- Cash, T., Kehr, J., & Salzbach, R. (1978). Help-seeking attitudes and perceptions of counselor behavior. Journal of Counseling Psychology, 25, 264-269.
- Cookerly, J. (1973). The outcome of six major forms of marriage counseling compared: A pilot study. Journal of Marriage and Family, 36, 608-611.
- Corrigan, J., Dell, D., Lewis, K., & Schmidt, L. (1980). Counseling as a social influence process: A review. Journal of Counseling Psychology, 27, 395-441.
- Crowe, M., Gillan, P., & Golombok, S. (1981). Form and consent in the conjoint treatment of sexual dysfunction: A controlled study. Behavior Research and Therapy, 19, 47-54.
- Dell, D., & Schmidt, L. (1976). Behavioral cues to counselor expertness. Journal of Counseling Psychology, 23, 197-201.
- Dies, R. (1980). Current practice in the training of group psychotherapists. International Journal of Group Psychotherapy, 30, 169-185.
- Duhl, B., & Duhl, F. (1981). Integrative family therapy. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 483-513). New York: Brunner/Mazel.
- Festinger, L. (1957). A theory of cognitive dissonance. Evanston, Ill.: Row and Peterson.
- Framo, J. (1981). The integration of marital therapy with sessions with family of origin. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 133-158). New York: Brunner/Mazel.
- Gazda, G., Asbury, F., Balzer, F., Childers, W., & Walter, R. (1977). Human relations development. Boston: Allyn and Bacon, Inc.
- Goldstein, A. (1966). Psychotherapy research by extrapolation from social psychology. Journal of Counseling Psychology, 13, 38-45.
- Gurman, A. (1971). Group marital therapy: Clinical and empirical implications for outcome research. International Journal of Group Psychotherapy, 21, 174-189.
- Gurman, A. (1973). The effects and effectiveness of marital therapy: A review of outcome research. Family Process, 12, 145-170.

- Gurman, A. (1977). Much vigor, little rigor. Contemporary Psychology, 22, 67-68.
- Gurman, A. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems theory approaches. In T. Paolino and B. McCrady (Eds.), Marriage and marital therapy (pp. 445-566). New York: Brunner/Mazel.
- Gurman, A. (1979). Dimensions of marital therapy: A comparative analysis. Journal of Marital and Family Therapy, 5, 5-16.
- Gurman, A., Kniskern, D. (1981). Family therapy outcome research: Known and unknowns. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 742-775). New York: Brunner/Mazel.
- Haley, J. (1971). A review of the family therapy field. In J. Haley (Ed.), Changing families (pp. 1-12). New York: Green and Stratton.
- Haley, J. (1973). Uncommon therapy. New York: W. W. Norton.
- Haley, J. (1976). Problem-solving therapy. San Francisco: Jossey-Bass.
- Hannum, J. (1980). Some co-therapy techniques with families, Family Process, 19, 161-167.
- Heppner, P., & Heesacker, M. (1983). Perceived counselor characteristics, client expectations, and client satisfaction with counseling. Journal of Counseling Psychology, 30, 31-39.
- Hoffman, L. (1976). Breaking the homeostatic cycle. In P. Guerin (Ed.), Family therapy: Theory and practice (pp. 309-311). New York: Gardner Press.
- Huck, S., Cormier, W., & Bounds, W. (1974). Reading statistics and research. New York: Harper and Row.
- Jacobson, N. (1978). A review of the research on the effectiveness of marital therapy. In J. J. Paolino and B. S. McCrady (Eds.), Marriage and marital therapy (pp. 395-444). New York: Brunner/Mazel.
- Jacobson, N., & Weiss, R. (1978). Behavioral marriage therapy: The contents of Gurman et al. may be hazardous to our health. Family Process, 17, 149-163.

- Jones, E., & Zoppel, C. (1982). Impact of client and therapist gender on psychotherapy process and outcome, Journal of Consulting and Clinical Psychology, 50, 259-272.
- Kaplan, H. (1974). The new sex therapy: Active treatment of sexual dysfunctions. New York: Brunner/Mazel.
- Kiresuk, F., & Sherman, R. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. Community Mental Health Journal, 4, 443-453.
- Kunin, C., & Rodin, M. (1982). The interactive effects of counselor gender, physical attractiveness and status on client self disclosure. Journal of Clinical Psychology, 38, 84-90.
- LaCrosse, M. (1977). Comparative perceptions of counselor behavior: A replication and extension, Journal of Counseling Psychology, 24, 464-471.
- LaCrosse, M. (1980). Perceived counselor social influence and counseling outcomes: Validity of the counselor rating form. Journal of Counseling Psychology, 27, 320-327.
- LaCrosse, M., & Barak, A. (1976). Differential perception of counselor behavior. Journal of Counseling Psychology, 23, 170-172.
- Levinson, D., Darrow, C., Klein, E., Levinson, M., & McKee, B. (1978). The seasons of a man's life. New York: Little, Brown.
- Liebman, R., Minuchin, S., Baker, L., & Rosman, B. (1976). The role of the family in the treatment of chronic asthma. In P. Guerin (Ed.), Family therapy (pp. 480-481). New York: Gardner Press.
- Lothstein, L. (1980). Co-therapy and supervision. In L. Wolberg and M. Aronson (Eds.), Group and family therapy (pp. 281-282). New York: Brunner/Mazel.
- MacLennan, B. (1965). Co-therapy. International Journal of Group Psychotherapy, 15, 154-165.
- Mann, B., & Murphy, K. (1975). Timing of self disclosure, reciprocity of self disclosure, and reactions to an initial interview. Journal of Counseling Psychology, 22, 304-308.
- Marmor, J. (1966). The nature of the psychotherapeutic process. In G. Udin (Ed.), Psychoneurosis and schizophrenia (pp. 113). Philadelphia: J. B. Lippencott, Co.

- Marmor, J. (1975). Psychiatrists and their patients: A natural study of private office practices. Washington, D.C.: American Psychological Association for Mental Health.
- Masters, W., & Johnson, V. (1970). Human sexual inadequacy. Boston: Little, Brown.
- Meer, J. (1986, June). Yours, mine and divorce. Psychology Today, June, pp. 13.
- Mehlman, S., Baucom, D., & Anderson, D. (1983). Effectiveness of co-therapists versus single therapists and immediate versus delayed treatment in behavioral marital therapy. Journal of Consulting and Clinical Psychology, 51, 258-266.
- Mintz, E. (1963). Special values of co-therapists in group psychotherapy. International Journal of Group Psychotherapy, 13, 122-126.
- Minuchin, S. (1969). Family therapy: Theory or technique? Science and Psychoanalysis, 14, 401-409.
- Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.
- Nadelson, C., & Paolino, T. (1978). Marital therapy from a psychoanalytic perspective. In T. J. Paolino and B. S. McCrady (Eds.), Marriage and marital therapy (pp. 89-164). New York: Brunner/Mazel.
- Napier, A., & Whitaker, C. (1978). The family crucible. New York: Harper and Row.
- O'Leary, K., & Turkewitz, H. (1978). The treatment of marital disorders from a behavioral perspective. In T. J. Paolino and B. S. McCrady (Eds.), Marriage and marital therapy (pp. 240-297). New York: Brunner/Mazel.
- Olson, D. (1970). Marital and family therapy: Intergrative review and critique. Journal of Marriage and the Family, 32, 501-538.
- Persons, R., Persons, M., & Newmark, I. (1974). Perceived helpful therapists' characteristics, client improvements, and sex therapist and client. Psychotherapy: Theory, Research and Practice, 11, 63-65.
- Press, A., Burger, W., Abramson, P., McCormick, J., & Cavazos, S. (1983, Jan. 10). Divorce American style. Newsweek pp. 42-48.

- Rabin, H. (1967). How does co-therapy compare with regular group therapy. American Journal of Psychotherapy, 21, 244-255.
- Rice, D., & Rice, J. (1977). Non-sexist 'marital' therapy. Journal of Marriage and Family Counseling, 3, 3-10.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Counseling Psychology, 21, 95-103.
- Roman, M., & Meltzer, B. (1977). Co-therapy: A review of current literature. Journal of Sex and Marital Therapy, 3, 63-77.
- Russell, A., & Russell, L. (1979). The uses and abuses of co-therapy. Journal of Marital and Family Therapy, 2, 39-46.
- Sager, C. (1981). Marital contracts. In G. P. Sholevar (Ed.), The handbook of marriage and marital therapy (pp. 35-76). New York: SP Medical and Scientific Books.
- Sager, C., Gundlach, R., Kremer, M., Lenz, R., & Royce, J. (1968). The married in treatment. Archives of General Psychiatry, 19, 205-217.
- Satir, V. (1967). Conjoint family therapy. Palo Alto, CA: Science and Behavior Books.
- Siddall, L., & Bosman, B. (1976). Co-therapy as a training process. Psychotherapy Theory, Research and Practice, 13, 209-213.
- Simons, J., & Helms, J. (1976). Influence of counselor's marital status, sex and age on college and non-college women's counselor preferences. Journal of Counseling Psychology, 23, 380-386.
- Skygger, A. (1976). Systems of family and marital psychotherapy. New York: Brunner/Mazel.
- Skygger, A. (1981). An open-systems, group-analytic approach to family therapy. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 39-84). New York: Brunner/Mazel.
- Sonne, J., & Lincoln, G. (1965). Heterosexual co-therapy team experiences during family therapy. Family Process, 4, 177-197.
- Sonne, J., & Lincoln, G. (1966). Importance of heterosexual co-therapy relationship in the construction of a family image. Psychiatric Research Reports, 20, 196-205.
- Stanton, M. (1981). Marital therapy from a structural/strategic viewpoint. In G. P. Sholevar (Ed.), The handbook of marriage and marital therapy (pp. 303-334). New York: Brunner/Mazel.

- Strong, S. (1968). Counseling: An interpersonal influence process. Journal of Counseling Psychology, 15, 215-224.
- Strong, S., Wambach, C., Lopez, F., & Cooper, R. (1979). Motivational and equipping functions of interpretation in counseling. Journal of Counseling Psychology, 26, 98-107.
- Sublich, L. (1983). Expectancies for counselor as a function of counselor gender specification and subject sex. Journal of Counseling Psychology, 30, 421-424.
- Tinsley, H., & Harris, D. (1976). Client expectations for counseling. Journal of Counseling Psychology, 23, 173-177.
- Tinsley, H., Workman, K., & Kass, R. (1980). Factor analysis of the domain of client expectancies about counseling. Journal of Counseling Psychology, 27, 561-570.
- Treppa, J., & Nunelly, K. (1974). Interpersonal dynamics related to the utilization of multiple therapy. American Journal of Psychotherapy, 28, 71-84.
- Vargas, A., & Borkowski, J. (1982). Physical attractiveness and counseling skills. Journal of Counseling Psychology, 29, 246-255.
- Watson, A. (1963). The conjoint psychotherapy of marriage partners. American Journal of Orthopsychiatry, 33, 912-922.
- Watzlawick, P., Weakland, J., & Fisch, R. (1974). Change principles of problem formation and problem resolution. New York: W. W. Norton.
- Weakland, J., Fisch, R., Watzlawick, P., & Bodin, A. (1974). Brief therapy: Focused problem resolution. Family Process, 13, 141-168.
- Whitaker, C. (1972/73). The chemistry of the extended family—an implosion can bring 'em back alive. Voices, 8, 42-44.
- Whitaker, C., & Keith, D. (1981). Symbolic-experiential family therapy. In A. S. Gurman and D. P. Kniskern (Eds.), Handbook of family therapy (pp. 187-225). New York: Brunner/Mazel.
- Williams, A., & Miller, W. (1981). Evaluation and research on marital therapy. In G. P. Sholevar (Ed.), The handbook of marriage and marital therapy (pp. 373-416). New York: Spectrum Publications.

BIOGRAPHICAL SKETCH

Glenda Elaine Isenhour was born July 25, 1950, in Rowan County, North Carolina, the first and only daughter of four children born to Glenn and Lelia Isenhour.

Ms. Isenhour's first 10 years following graduation from Parkland High School in Winston-Salem, N.C., were spent traveling with her military husband, mothering her infant daughter and working in a number of medical assistant positions.

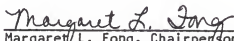
She began her undergraduate studies at Winston-Salem State University in 1978. Majoring in psychology, Ms. Isenhour graduated with honors, May, 1981. During this time, she was also employed as an advocate/counselor for Battered Women's Services, Inc. This position included conducting support groups, crisis-counseling and community education.

Ms. Isenhour and her daughter, Caroline Flinchum, moved to Gainesville, Florida, in August, 1981, so that she could begin her graduate studies in the Counselor Education Department at the University of Florida. She received her M.Ed. and Ed.S. degrees in agency and community counseling in December, 1983. While working as the graduate assistant to the chairperson of the Counselor Education Department, Ms. Isenhour continued with her doctoral studies, with specialization in marriage and family therapy. She was professionally active in the

American Association for Counseling and Development divisions, serving two consecutive years as the Southern District Coordinator for the American Mental Health Counselors Association and as Secretary for the American School Counselor Association. She also conducted and assisted with a number of consultative workshops for school psychologists, teachers, and administrators throughout the state of Florida and assisted faculty with teaching graduate courses in the Counselor Education Department at the University of Florida.

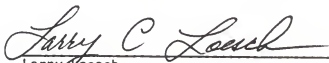
Ms. Isenhour will be joining the graduate faculty in the Counselor Education program at the University of Alabama following the award of her doctoral degree.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



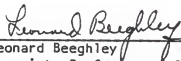
Margaret L. Fong, Chairperson
Associate Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Larry C. Loesch
Professor of Counselor Education

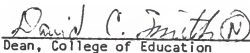
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Leonard Beeghley
Associate Professor of Sociology

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August, 1986



Dean, College of Education

Dean, Graduate School